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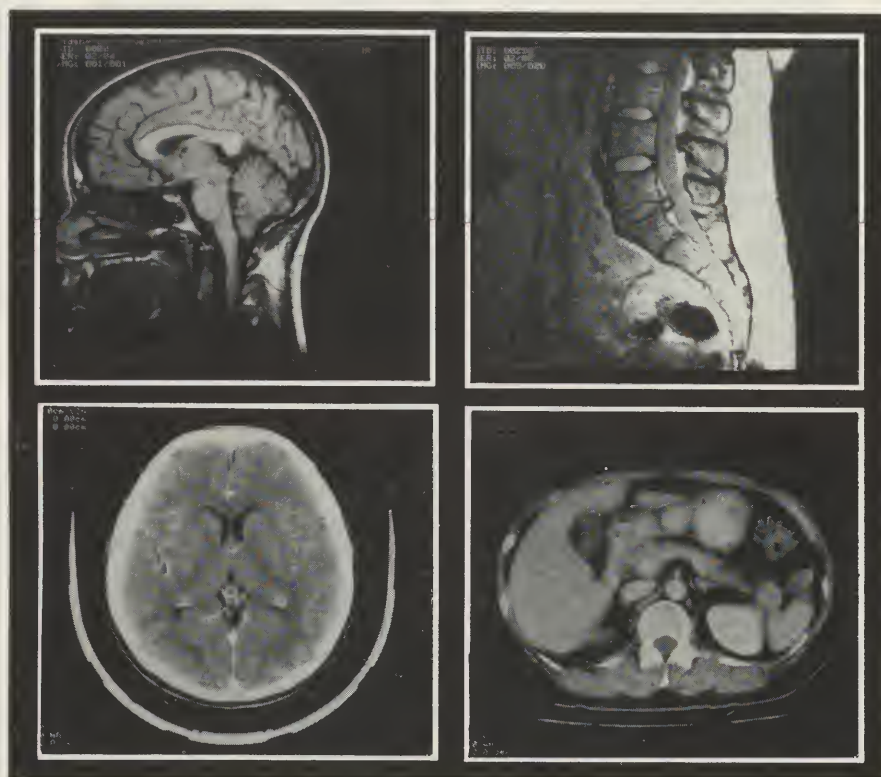
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MMJ

Maryland Medical Journal

JANUARY 1992

VOLUME 41 NO 1

Legislative preview: An overview of legislative issues affecting Maryland medicine in 199225

Gerard E. Evans, Esq.

During the 1992 legislative session in Maryland, medicine will face a variety of issues, some old and familiar, and others that bring new challenges.

Providers with HIV/AIDS — A new dilemma31

Katherine Karker-Jennings, Esq. and Michael F. Berkey, Esq.

Recently, a great deal of attention has been focused on health care providers who have or may have the human immunodeficiency virus or, as it is known in its later stages, acquired immunodeficiency syndrome. This article explores some of the duties physicians have, or soon may have, to their patients and employers in the areas of testing, disclosure, and practice restraints.

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The Maryland State House in Annapolis.

Cover photo and design by Virginia Carter



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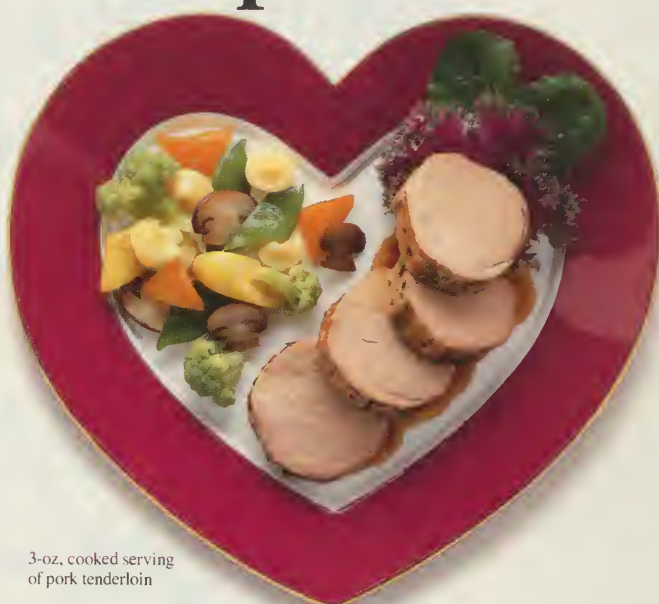
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Today's Pork: Compare it to chicken for a healthy surprise

You may not have considered pork to be a healthy choice for your patients on fat-modified diets. But today's fresh pork compares surprisingly well to chicken in total fat, saturated fat, cholesterol, and calories.^{1,2*}

New study: Pork is now 31% leaner

Pork is leaner today because of significant changes made in breeding and feeding techniques.¹ According to a new study conducted in cooperation with the USDA, fresh pork contains an average of 31% less fat after cooking and trimming than the same cuts reported in 1983.¹

Today's pork fits well within the dietary guidelines recommended by both the American Heart Association and the National Cholesterol Education Program. Here's some advice to help patients on low-fat diets enjoy the variety, extra taste, and versatility of pork:

- Choose the leanest cuts. Shop for cuts with "loin" in the name.
- Trim away any visible fat.
- Keep portions moderate (about 3 oz, cooked).
- Prepare by broiling or roasting, and avoid additional fat in preparation.

1. Buege DR, et al. *A Nationwide Survey of the Composition and Marketing of Pork Products at Retail*. University of Wisconsin; 1990.

2. US Dept of Agriculture. *Composition of Foods: Poultry Products*. Washington, DC: US Govt Printing Office; 1979. Agricultural handbook 8-5.

	Calories	Total Fat	Saturated Fatty Acids	Cholesterol
Chicken Breast, skinless	140	3.0 g	0.9 g	72 mg
Pork Tenderloin, trimmed	133	4.1 g	1.4 g	67 mg
Pork Top Loin Roast (boneless), trimmed	160	6.4 g	2.4 g	66 mg
Center Loin Chop, trimmed	165	6.9 g	2.5 g	70 mg
Chicken Thigh, skinless	178	9.2 g	2.6 g	81 mg

*Table refers to 3-oz, cooked (roasted) servings.

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A safe treatment for hyperemesis gravidarum?

In the September *MMJ*, Dr. Trachtenberg described a "simple and safe treatment regimen" for hyperemesis gravidarum. He describes a case in which the multiple episodes of hyperemesis gravidarum were treated with lorazepam with apparently good outcome.

Upon my review of the *Physicians' Desk Reference*, I note the warning in large capital letters, "Lorazepam may cause fetal damage when administered to pregnant women," and subsequently the statement, "Lorazepam injection should not be used during pregnancy."

Given today's litigious climate, I would caution physicians to be aware that this proposed treatment method is at variance with standard recommendations, at least as conveyed in the *Physicians' Desk Reference*. I would also question whether one case report can be used to determine that a treatment regimen is indeed safe.

WILLIAM D. HAKKARINEN, M.D.
Baltimore



Lorazepam during pregnancy: Another view

Dr. Hakkarinen's report of the printed *PDR* warning regarding the use of lorazepam during pregnancy is accurate and cause for concern, in terms both of our current litigious climate, and the possibility of fetal damage.

I have twice contacted the professional relations pharmacologists at Wyeth who assure me that they are aware of no reports of injury to the child of a pregnancy during which the mother has used lorazepam. Corresponding sources at Roche Laboratories however, do cite a few reports of cleft palate connected with the use of diazepam.^{1,2,3} A report in *Lancet* in 1975 found a four-fold incidence of cleft lip, with or without cleft palate, but concluded that "it is quite possible that it is simply due to chance." The most recent review I have seen appeared in the *New England Journal of Medicine* in 1983,⁴ entitled "Lack of relation of oral clefts to diazepam use during pregnancy." My own Medline search reveals no studies in the last ten years. I continue to believe that any risk to the fetus is very small, if present at all.

I would point out that a trial of lorazepam might well involve only one 1.0 mg injection; if the patient does not respond, treatment ceases. If she does, then the remainder of the medication can be given orally. Everyone would agree that, especially during the first trimester of pregnancy, any drugs are best avoided. Yet, if the attending physician feels that a trial of lorazepam might be justified by the debilitation and suffering of an individual patient, perhaps the decision to try it might be arrived at together with the patient and her family.

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1. Safra MJ, Oakley GP. Association between cleft lip with or without cleft palate and prenatal exposure to diazepam. *Lancet* 1975; 2:478-80.
2. Safra MJ, Oakley GP. Valium: An oral cleft teratogen? *Cleft Palate J.* 1976; 13:198-200.
3. Saxen I, Saxen L. Association between maternal intake of diazepam and oral clefts. *Lancet* 1975; 2:498.
4. Rosenberg L et al. Lack of relation of oral cleft to diazepam use during pregnancy. *N Engl J Med* 1983; 309(21):1282-85.

DAVID TRACHTENBERG, M.D.
Bethesda



Too busy to write?

Are you too busy with your medical practice to write for your peers? Then, hitch your wagon to a star as Copernicus did about 500 years ago. Living in the academically poorly oriented times of medieval Europe, he looked at the firmament and formulated revolutionary concepts of celestial mechanics to give the world a concept of infinite space. Accomplished a century before the invention of the telescope, his work was done at night with poor light and wooden instruments marked with ink. He defined the rotation of the earth on its axis; its orbit around the sun; and the variation in inclination of the earth to the ecliptic. Newton confirmed the obliquity of the ecliptic a century later.

You say "Copernicus was an astronomer who looked only at the stars." Did you know that besides being a scholar and researcher, he also was a philologist, an economist, a mathematician, and a physician? Busy as he was, he devoted much of his time to the practice of medicine on a daily basis. He was a doctor to bishops, princely advisors, and peasants.

Copernicus looked at the stars and wrote *De Revolutionibus Orbium Coelestium* but he also had time for many other pursuits. Milton probably thought of Copernicus when he composed these memorable lines in *Paradise Lost*:

In six thou seest, and what if sev'nth to these
The Planet Earth, so steadfast though she seem
Insensibly three different motions move.

We would all agree that modern medicine is a harsh taskmaster and demanding of our time, but the schedule of Copernicus would shame many of us. Yet he found time to write and share his research results with his peers.

The communication of experience and knowledge to colleagues (through case studies or literature reviews, for example), benefits the writer and the reader. The quality of care we provide to the patient is enhanced. If Copernicus could find the time to write, so can you. Share your knowledge and publish in the *Maryland Medical Journal*.

JOSEPH M. MILLER, M.D.
Timonium



Current challenges in medical practice and research*

Beginning with the second half of the 20th century, the leading causes of death in Baltimore, as elsewhere in the United States, were heart disease, cancer, stroke and other cerebrovascular diseases, and automobile accidents. Even now, predominantly in the large pockets of poverty in our affluent country, about 40,000 liveborn children die each year before their first birthday. Recently, some people have called AIDS (acquired immunodeficiency syndrome) the plague of the latter part of the 20th century. I do not share this view. In my judgment, AIDS is an important new infectious disease in which cells of the immune system are destroyed, but its spread is predominantly among people with a lifestyle characterized by promiscuous, male homosexuality and intravenous drug abuse. It cannot be regarded as a threat to the general population. It is, in my judgment, receiving disproportionate public support for medical care and research.

It also seems to me that the important health challenges of the present era in economically developed countries cannot be measured only by the leading causes of death, but must also be measured by the many conditions that contribute to the misery of the living.

Among the latter is Alzheimer's disease, in which the progressive and irreversible loss of brain function stops one from being a person, and life as a human being stops while life as a human vegetable continues for many years. According to reliable estimates, there are now about four million persons with Alzheimer's disease in the US, and the number is growing annually as the number of persons 65 years of age and older continues to increase—from over 31 million today to possibly 70 million in 40 years. The misery Alzheimer's disease causes is not in the people who develop it, because they are unaware of what is going on, but in the millions of family members related to victims of Alzheimer's disease and in the society in which those with Alzheimer's continue to live as vegetables.

Let me now mention other conditions that are important as sources of human misery rather than mortality in the US. There are millions of persons with limitations of mobility caused by osteoarthritis, so-called rheumatism, rheumatoid arthritis, and neurological conditions resulting from stroke, Alzheimer's disease and multiple sclerosis. There are millions with visual, hearing, and dental impairments. And, although many people think that infectious diseases are no longer important health problems from a numerical point of view, they disregard the important findings of the national health surveys carried out by the National Center for Health Statistics that indicate that about 60 percent of the entire U.S.

population (i.e., about 151 million people) *each year* suffer from acute respiratory illnesses of sufficient severity to put them to bed for periods of two to four days. Vaccines, for a variety of reasons, have proved ineffective in dealing with this respiratory disease problem and, in my judgment, cannot meet this challenge. I believe we need a totally different kind of research dealing with the physiologic causes of the disabling symptoms rather than with the great variety of known and unknown viruses which are the etiologic agents of these illnesses.

The historically unprecedented explosion of new knowledge that medical research has provided during the past 50 years has brought both blessings and problems. It is self-evident that the main function of medical research is to provide the knowledge for good medical practice. Even I remember the days "when medical practice was 90 percent compassion and 10 percent knowledge. Now the reverse is true. There seems to be no time left for compassion, without which the practice of medicine cannot fulfill its real function. Putting compassion back into medical practice faces all sorts of difficulties that, in my judgment, must be overcome, and can only be overcome by a reorganization of the old patterns of medical practice. These difficulties are to a large extent a consequence of the aforementioned extraordinary explosion of new knowledge and the sophisticated technologies that medical research has brought forth in recent decades and will have to continue to bring forth to meet the challenges of the many diseases that make our lives miserable... Ever greater specialization has become absolutely essential and unavoidable to bring the benefits of the knowledge brought forth by medical research to those whose very lives may depend upon it."¹

My own survival to age 84 is, in large measure, due to the new knowledge and technologies that have permitted me to have two coronary bypass procedures (1972 and 1988), that have provided the new technologies used in 1983 to bring me back to life when an extensive paralytic illness brought on life-threatening respiratory arrest and loss of consciousness, and, more recently, that have given me the knowledge that a calorically restricted diet is the best way to control my Type II diabetes.

"However, the unavoidable need for specialization has led to a great disproportion in those who choose the more highly remunerative specialties. Already in 1981, almost 90 percent of physicians in the United States were said to be specialists compared to only about 17 percent in 1931... We cannot turn back the clock to the time when individual doctors, full of compassion but with insufficient knowledge, were called upon to provide total health care for the major portion of the population. Perhaps the most important specialty for which there is now the greatest need, is the specialty that would train physicians how best to obtain, integrate, and coordinate the information that the organ-, function-, and disease-oriented specialties can contribute to the total care of the patient in the

* Part of keynote address at Academic Session for the 125th anniversary of the Sinai Hospital of Baltimore, April 27, 1991.

truly satisfying doctor-patient relationship that we should not forsake in the process of adaptation to the new situation... It is this total care physician who, more than any other specialist, will have to provide the compassion and human understanding without which the practice of medicine would lose one of its most important components... Compassion without knowledge is helpless, and knowledge without compassion is insufficient for the practice of medicine. The most important current challenge is how best to achieve these desirable objectives within a framework that meets the justifiable expectations of society for optimal human health care without reference to the ability of individuals to pay for the ever-increasing and currently almost prohibitive costs of such care... I see a need for [universal] prepaid health insurance to cover all costs of health maintenance — prevention, ambulatory, medical, [surgical], dental, optical and, when [absolutely] necessary, hospitalization... Such systems [have been] in successful operation for many years in the United States by private organizations such as the Kaiser-Permanente Group on the West Coast and the Health Insurance Group of New York, where people are insured at a cost they can afford for the total health care of the family, and where the physicians who work there full-time can make decisions and spend the necessary time with their patients without being influenced by the fee-for-service they would receive."¹

"In my view, there is also a great need for modification of the ways in which the priorities for medical research are being planned and implemented in the present era. Just as in medical practice, so in medical research, ever greater specialization has become a necessary and unavoidable way in which to achieve progress... Consequently, there is often a loss of perspective regarding the major problems that urgently call for concentrated [and coordinated] studies and the priorities that unavoidably must be established for optimal use of the funds that society can afford to supply for the medical research enterprise."¹

And what should our main goal for biomedical research be? Should it be prevention of death from life-threatening diseases that *prematurely* bring our lives to the inevitable end? At the present time, about 75 percent of the deaths in older persons in the US are caused by heart disease, cancer, and stroke. It has been estimated that eliminating deaths from heart disease would add seven years to life expectancy at age 65. If cancer were entirely eliminated as a cause of death, life expectancy at age 65 would be extended by two years, and more persons would then die of heart disease and other causes. For me, it is the misery caused in older persons by chronic heart disease, cancer, and stroke and *not* the shortening of our life span that should form the basis for the ongoing search for greater understanding and ultimate elimination of these diseases. And, as I indicated above, the greatest tragedy among older persons is the progressive, irreversible loss of normal brain function that occurs in Alzheimer's disease.

I have been saying for many years, that "the ultimate goal of biomedical research in the present era [should be] to make

it possible for all of us to live out the allotted life span [of our species] with essentially unimpaired mental and physical functions, and *to die in good health* by a sudden stopping of an essential vital function that is regulated by the so-called biological clock. This type of death has long been the good fortune of many people, who in their 80s and 90s are in good physical and mental condition, and who go to sleep one night and never wake up."¹ This is the way I would like to die — preferably while listening to soul-stirring music or reading a book. It has happened to some of my friends, why not to me?

"I believe that it is not too much to expect that one day, step by step, biomedical research will come up with the knowledge that will make this type of death possible for all. This is a big goal and like all big goals in science or any other enterprise, it must be divided into smaller pieces of action — all, however, ultimately designed to lead up to the large goal... In this respect, the most important aspect of biomedical research is categorical basic research, i.e., an entirely mission-oriented, problem-solving activity, and *not* noncategorical basic research, which is a curiosity-oriented scientific enterprise — also important, but unrelated to any specific problem. It is self-evident that progress in biomedical research is inevitably dependent on progress in many other fields of scientific endeavor, especially, in all those fields designated as life sciences, the sciences that give us ever greater understanding of the miracle that is life."¹

"But life science research is not biomedical research. The questions must be different... There are so many millions of questions to be asked, that without a properly planned division of labor, progress in problem-oriented research can be unacceptably slow... Can the tremendous amount of new, specific knowledge needed to deal with the many unsolved disease problems... best be acquired only by *good* individual scientists pursuing their own individual interests which at best can deal with only very small pieces of very large problems? Is the old academic formula of finding good men or women, giving them what they need and leaving them alone, the *only* [I emphasize only] way to deal with the large mission-oriented research problems?"¹

"There is no question that research of individual good scientists — investigator-initiated research in current parlance — has resulted in many important medical advances... I believe [however] that problem-solving biomedical research [also] needs [more than] individual [analysis and] planning for optimal [definition] of the problems (not protocols for research) and for optimal utilization of different disciplines in ongoing collaborative efforts to seek solutions. What I have in mind can also be regarded as investigator-initiated categorical basic research — not of single investigators — but of groups of [interdisciplinary] investigators who would plan together and work together in such a fashion that their work could be combined to illuminate larger segments of the total problem. Such groups of investigators for interdisciplinary planning and collaborative execution of these plans cannot be expected to arise spontaneously. Bring-

ing such groups into being, in my judgment, should be one of the important intramural and extramural activities of the many *categorical* National Institutes of Health that were created by the government to deal with specific human disease problems."¹

I am enough of an optimist to believe that, sooner or later, the many problems that are now the principal causes of human misery caused by disease will be solved by the relentless pursuit of medical research, and that with greater wisdom in acquiring and using new knowledge, we may achieve a life far better than any the human race has known before.

My optimism is in the same category as the words used by Joseph Friedenwald, the first president of the Hebrew

Hospital of Baltimore in his 1868 annual report. He said: "Whilst we have every reason to congratulate ourselves on the working of this institution up to this time, there yet remains much to be done, *but no thing which is impossible to accomplish*"² (my emphasis).

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2. Coppage RS. Sinai Hospital: Its past and present. The Johns Hopkins Nurses Alumni Magazine 1985; 85:9-14.

ALBERT B. SABIN, M.D.
Washington, DC

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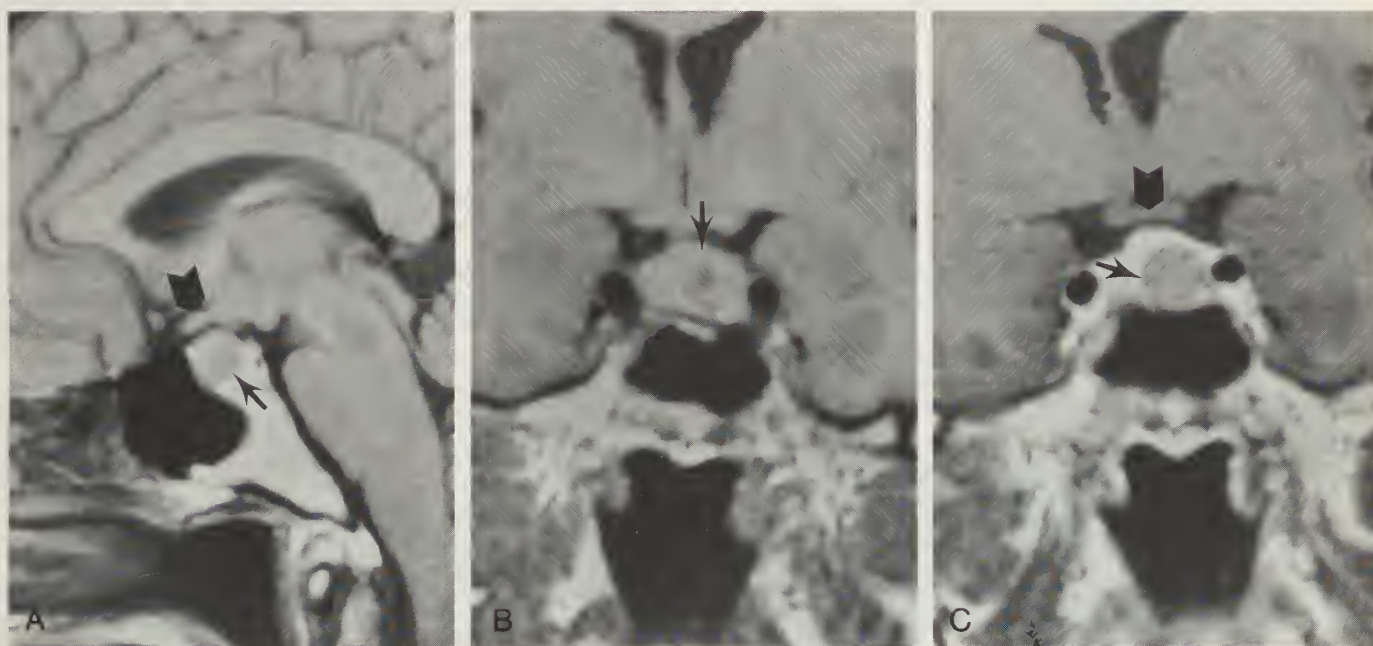
49 y.o. female with a six month history of headache, mild bilateral temporal hemianopsia and enlargement of the feet and hands.

DIAGNOSIS: Pituitary Adenoma.

Sagittal (A) and coronal (B) MRI images demonstrate enlargement of the pituitary gland with depression of the floor of the sella turcica on the left (arrow) and superior extension into the suprasella cistern. Although the mass is in close proximity to the optic chiasm (arrowhead) there is no chiasmatic compression. The coronal MRI image obtained following Gadolinium DTPA administration (C) demonstrates a focal round 10 mm area of non-enhancement involving the central and left lateral aspect of the pituitary gland. The lesion extends to the margin of the left cavernous sinus but does not invade it.

Pituitary adenomas are slow growing, benign neoplasms of epithelial origin which arise from the adenohypophysis. Clinical presentation of pituitary adenomas depends on the size of the lesion, the presence or absence of hormonal activity, the type of hormone produced and the degree of extra-sellar extension.

Multi-planar imaging, lack of bone artifact and ability to demonstrate adjacent vascular structures make MRI an excellent technique in the assessment of pituitary adenomas. The procedure accurately documents the relationship of the mass to the optic nerves, chiasm and tracts, the sphenoid sinus, and the cavernous sinuses. In that MRI involves no ionizing radiation, it is also ideal for serial follow-up of pituitary tumors.



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In appreciation

The members of the Editorial Board of the *Maryland Medical Journal* are most grateful to various specialists in the Maryland medical community who graciously contribute their time and expertise to the review of manuscripts for our publication. In 1991, the following individuals assisted in *MMJ*'s review process:

Thomas E. Allen, M.D.
Mark M. Applefield, M.D.
John G. Bartlett, M.D.
William R. Bell, M.D.
Peter O. Kwiterovich, Jr., M.D.
H. Lorin Lau, M.D., M.P.H.
Martha Jane Matjasko, M.D.
Travis Meredith, M.D.
Charles A. Schiffer, M.D.



Lupus Foundation grants

The Lupus Foundation of America, Inc. (LFA) has announced the availability of application forms for the 1992 LFA Research Grant Program. Grants are made to investigators for up to two years (\$15,000 per year) to support biomedical research related to finding the cause(s) and/or cure for lupus erythematosus. Each research grant proposal will be competitively reviewed and ranked by several members of the LFA Medical Council or outside experts in the field of proposed study. This year, five grants will be awarded, with funding to begin July 1, 1992. Applications can be obtained from: Lupus Foundation of America, Inc.; Suite 180; 4 Research Place; Rockville, MD 20850-3226 (301-670-9292). Applications must be received no later than February 3, 1992.



An atmosphere of understanding

The Maryland Chapter of the Crohn's and Colitis Foundation of America (CCFA) has developed support groups for patients suffering from either of these chronic inflammatory bowel diseases. The groups are organized to serve the needs of adolescent, young, young adult, and older patients and their families. Enrollment is free. Participants continue to receive care from their personal physicians while benefiting from an atmosphere of understanding and companionship provided by others whose experiences have taught them how to cope with the stress of these illnesses.

For more information, please call CCFA, Maryland Chapter at 410-486-9501. ■

Manuscripts may be sent to Editor, *MMJ*, 1211 Cathedral St., Baltimore, MD 21201-5585. Articles are accepted for publication on the condition that they are contributed solely to this journal. Transmittal letters should designate one author as correspondent and include his/her address and telephone number. Manuscripts are reviewed by editorial board members and guest reviewers.

Specifications

Manuscripts must be original typed copy, double-spaced throughout (including text, case reports, legends, tables, and references), with pages numbered consecutively. Along with manuscripts, please send an IBM-compatible floppy disk, with the document entered in a WordPerfect or ASCII format.

Include full name of author(s) with highest degrees and academic or professional titles.

Tables with brief descriptive titles are to be typed on separate sheets of paper and numbered. The Editor reserves the right to edit tables. Statistics must be consistent in both tables and text.

An introductory synopsis of approximately twenty-five to fifty words is required.

References are limited to those citations noted in the text and are to be typed double-spaced and numbered consecutively as they appear in the text. The number of references generally is limited to twenty in major contributions and fewer in shorter articles. Personal communications and unpublished data should not be included.

Photographic material must be submitted as high-contrast glossy prints. Drawings and graphs must be of professional quality. Recognizable photos of patients are to be masked and should carry with them written permission for publication.

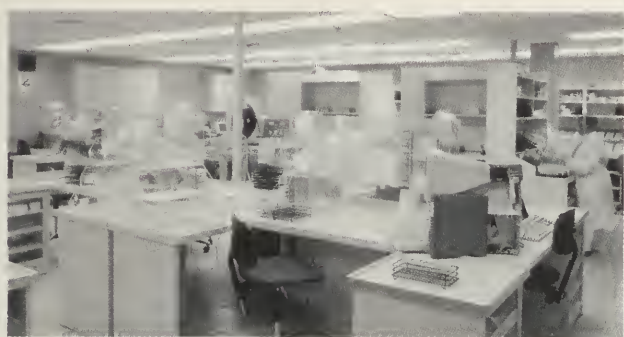
For more extensive information about preparing medical articles for publication, see *Uniform Requirements for Manuscripts Submitted to Biomedical Journals* compiled by the International Committee on Medical Journal Editors (available through the *Annals of Internal Medicine*).

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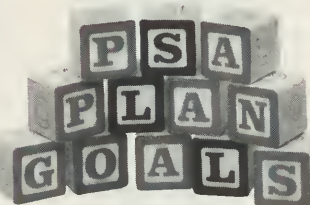
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Rapid closing of ulcer.

The common denominator of most leg ulcers is venous pump failure with edema. Our treatment first removes the edema and heals the ulcer through the application of isometric compression bandaging. This increases venous outflow during ambulation, resulting in improved pump action at the calf muscle.

Healing occurs in three to six weeks for most patients, or longer in more advanced cases. Other advantages of this phase include immediate ambulation, rapid elimination of pain and drainage and high patient acceptance.



D.K., a 69-year-old woman with recurrent ulcer and history of skin graft failures, on initial day of treatment. Edema of ankle and inflammation clearly visible.

Effective long-term healing.

Once the ulcer has healed and other problems such as edema and dermatitis are under control, the second phase of treatment can address prevailing underlying causes. Refluxing venous trunks, tributaries and incompetent perforating veins are

eliminated by injection compression sclerotherapy, often guided by Duplex Color Ultrasound.

This selective fibrosis process improves the venous pump, resulting in long-term healing and lowered recurrence of leg ulcers.

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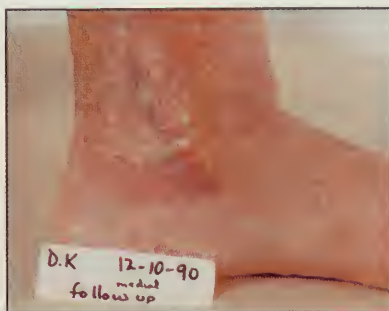
This treatment protocol was developed over 10 years of clinical experience, with favorable results on approximately 500 leg ulcer patients.

Many patients had previous surgery with skin grafting and vein stripping. But our two-step protocol provided more effective healing. This is because the treatment is directed at the underlying cause, the venous pump failure.

For information on how your patients can benefit from this treatment call Louis Ivey, MD, Eastern Region Medical Director at (301) 654-6633.



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Gaylord Lee Clark, Jr., M.D.
Peter C. Innis, M.D.
Michael A. McClinton, M.D.
J. Russell Moore, M.D.
E.F. Shaw Wilgis, M.D.
Neal B. Zimmerman, M.D.

Seasonal Injuries Can Be Avoided

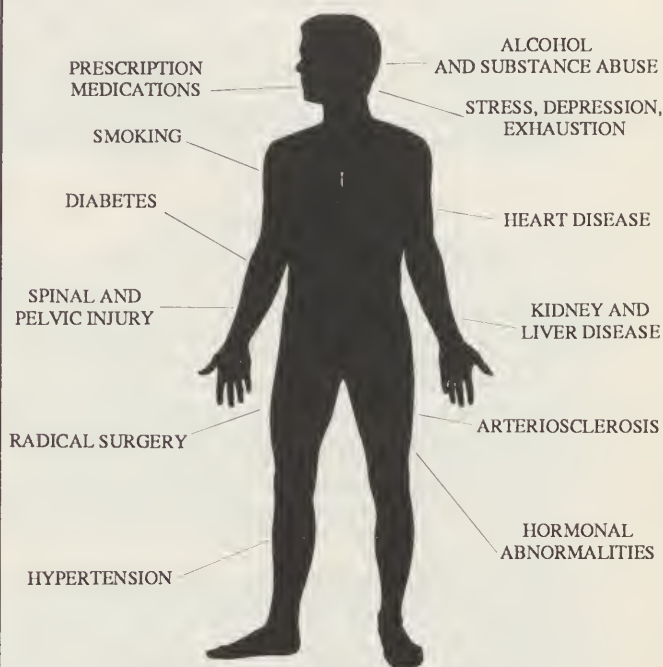
Take a moment and look at your hands. They are versatile, tough, delicate and complex. They are irreplaceable. Once damaged by injury, they may never function normally again. Seasonal injuries are quite common. Doctors and specialists are seeing severe damage to fingers with fractures and amputations from snow blowers. Never place your hand in the chamber with the snow blower blades. Always use an instrument such as a stick. The blade may rotate after it is freed even if the engine is turned off. Never drink an alcoholic beverage or use drugs before operating your equipment. You will unwittingly impair your judgement and slow your reflexes thus increasing your chance of injury. Hands are the God given extensions of your mind. For more information relating to hand and arm care and safety please contact Greater Chesapeake Hand Specialists - 296-6232.

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meeting should see page 36 of this MMJ. Watch the *Maryland Medical Journal* for the preliminary program and more meeting information.

President's Regional Conference - Southern Md.

The President's Regional Conference for southern Maryland is tentatively scheduled for March 1992. Watch the Executive Director's Newsletter for more information about this conference or contact Betsy Newman, Public Relations Director, at 410-539-0872 or 1-800-492-1056.

Doctor/Lawyer/Teacher Partnership

Physicians in Baltimore City and Harford County are urgently needed to prevent drug abuse in Maryland's school children. As a physician volunteer in the Doctor/Lawyer/Teacher Partnership Against Drugs, physicians will spend a few hours of their time visiting a classroom of students and discussing the medical dangers of using drugs. Training sessions for physicians interested in participating in this program will be held on Tuesday, January 14 and Wednesday, January 22, 1992 from 6 to 8 p.m. in the Med Chi Faculty Building. All physicians who participate in this program will receive a certificate of appreciation and will be recognized during Med Chi's 1992 Annual Meeting. To volunteer or for more information, contact Betsy Newman, Public Relations Director, at 410-539-0872 or 1-800-492-1056.

Office Medical Records Booklet

The Office Medical Record: Confidentiality and Disclosure, a compendium of legal and ethical guidelines for physicians and their office staff, is now available for Med Chi physicians. The booklet, which was developed by Med Chi and the Medical Mutual Liability Insurance Society of Maryland, answers many commonly asked questions about the release, maintenance, and destruction of medical records. Med Chi members can order a free copy of this booklet by calling Med Chi's Communications Department at 410-539-0872 or 1-800-492-1056.

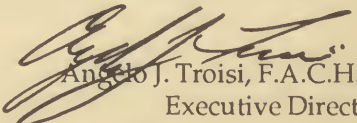
Medicare Legislation

Med Chi thanks its physicians for their hard work and efforts to encourage Maryland U.S. Representatives to support H.R. 3070 and S. 1810. Currently, 100 percent of Maryland Representatives have signed on as cosponsors of these bills which will lessen the "conversion factor" reductions proposed by the Health Care Financing Administration (HCFA).

If passed, H.R. 3070 will eliminate the 16 percent reduction in Medicare payments for physician services which was originally proposed in the Notice of Proposed Rule Making (NPRM) for the resource-based relative value scale (RBRVS) payment reform system scheduled to take effect on January 1, 1992.

According to the AMA's *Hospital Medical Staff Section Newsletter*, "S. 1810 would eliminate the cuts made to the RBRVS payments due to asymmetry and would allow a 1 percent behavioral offset reduction in reimbursements, to be divided between the conversion factor and the historical adjusted payment base. The legislation would also allow payments for electrocardiogram (EKG) interpretations, maintain the current payment methodology for drugs provided as 'incident to' a physician's services, and continue the use of time in determining payment for anesthesia services."*

Med Chi appreciates the support of its physicians and Maryland Representatives on these critical pieces of legislation and will keep Maryland physicians apprised of continuing developments with the NPRM and RBRVS and the Medicare system.


Angelo J. Troisi, F.A.C.H.E.
Executive Director

* AMA Hospital Medical Staff Section Newsletter, Volume 8, Number 11, November 1991.

TO MY PATIENTS

When I refer you to a specific health care facility for medical tests or services, you may go to that facility or any other* to have the tests or services completed. As you make this decision, I want you to know that I or members of my immediate family own a business interest in the following health care facilities:

Please feel free to ask me any questions you may have about your care. I am always interested in your continued good health.

Physician's Signature

* (unless you belong to an HMO and your plan requires that you use a particular facility.)



★ ★ ★ **IMPORTANT** ★ ★ ★

***MARYLAND LAW REGARDING NOTICE OF OWNERSHIP
OF OTHER HEALTH CARE SERVICES***

Effective July 1, 1991, Maryland law requires physicians to post a notice in their offices regarding their ownership of other health care services to which the physician refers patients. (see back)

The law, which is outlined in Section 1-206 of the Health Occupations Article of the Annotated Code of Maryland, states in part:

A health care practitioner may refer a patient or direct an employee of the practitioner to refer a patient to a health care service in which the practitioner, the practitioner's immediate family, or the practitioner in combination with the practitioner's immediate family owns a significant beneficial interest, if prior to the referral the practitioner:

- (I) Except if an oral referral is made by telephone, provides the patient with a written statement that:
 - 1. Discloses the existence of the ownership of the significant beneficial interest;
 - 2. States that the patient may choose to obtain the health care service from another provider of the health care service; and
 - 3. Requires the patient to acknowledge in writing receipt of the statement;
- (II) Except if an oral referral is made by telephone, inserts in the medical record of the patient a copy of the written acknowledgement;
- (III) Displays a written notice that is plainly visible to the patients of the practitioner disclosing all of the health care services:
 - 1. In which the practitioner, the practitioner's immediate family, or the practitioner in combination with the practitioner's immediate family owns a significant beneficial interest; and
 - 2. To which the practitioner refers patients; and
- (IV) Documents in the medical record of the patient that:
 - 1. A valid medical need exists for the referral; and
 - 2. The practitioner has disclosed the existence of the significant beneficial interest to the patient.



I am interested in serving on the following Med Chi committee(s):

Each year Med Chi requests physicians to serve on its more than 45 committees. These committees are the backbone of our organization and guide the decisions made by Med Chi's House of Delegates, Council and Executive Committee. To assure that Med Chi remains a strong and active organization, it is essential that physicians participate as active members of these committees.

As President for 1992-93, I intend to appoint as many physicians as possible to committees. Please indicate your willingness to serve by checking your preference and special interests on the attached reply card. Every effort will be made to appoint you to the committee of your choice.

Med Chi is your organization. By serving on a Med Chi committee, you can help protect and improve Maryland medicine.

Thank you for your assistance

Jose M. Yosunico MD
President-elect

- ☐ AIDS
- ☐ Alcoholism and Chemical Dependency
- ☐ Computers in Medicine
- ☐ Continuing Medical Education Review
- ☐ Drugs
- ☐ Emergency Medical Services
- ☐ Finance
- ☐ Focused Professional Education
- ☐ Hospital Medical Staffs
- ☐ Insurance Fund of Med Chi
- ☐ Legislative
- ☐ Liaison Committee with Medical Assistance Program
- ☐ Library and History
- ☐ Long-term Care and Geriatrics
- ☐ Managed Care and Third Party Liaison
- ☐ *Maryland Medical Journal* Editorial Board
- ☐ Medicine and the Performing Arts
- ☐ Medicine and Religion
- ☐ Mediocolegal
- ☐ Mental Health

☐ Other Interests: _____

Name: _____

Address: _____

City: _____ Zip: _____ County: _____

- ☐ Occupational Health
- ☐ Peer Review
- ☐ Peer Review Management
- ☐ Physician\Patient Relations
- ☐ Physician Rehabilitation
- ☐ *Physician's Practice Digest* Editorial Board
- ☐ Professional Ethics
- ☐ PRO Monitoring
- ☐ Public Health
 - ☐ Immunization and Infectious Diseases Subcommittee
 - ☐ Infant, Child & Adolescent Health Subcommittee
 - ☐ Maternal Welfare Subcommittee
 - ☐ Sports Medicine Subcommittee
- ☐ Public Relations
- ☐ Small Area Practice Variations
- ☐ Specialist Identification
- ☐ Specialty Societies
- ☐ Young Physicians

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You know the patient. The one with chronic psychosis that hasn't responded to general inpatient care. The patient has comprehensive coverage so you've been able to admit him time and time again for inpatient care. But there's been little if any improvement, and you're frustrated. It's time to refer him to a hospital that is committed to treating the long term refractory patient and has the resources to do it. Sheppard Pratt.

Today's literature discourages long term hospitalization, and we agree. That same literature does, however acknowledge that a small group of chronic patients cannot be treated any other way. In 1984, Sheppard Pratt opened an 18 bed unit that treats only those types of patients.

We are not talking about custodial care nor do we treat patients who spend years talking about delusions. We provide long term, active, behavioral, psychopharmacological treatment for those patients who can genuinely be helped.

In addition to managing systematic and aggressive medication trials, our patients live within an established token economy. Patient education and social skills programming, and specialized activity therapy are provided daily throughout treatment. Formalized psychoeducation is also a vital component of treatment and family involvement. Comprehensive discharge planning is given attention equal to inpatient care. Sheppard Pratt provides many options for aftercare including a quarterway house, supervised housing, vocational training, outpatient therapy and medications management, and day hospitals.

Sheppard Pratt is a comprehensive network of psychiatric services. In addition to our 322 bed hospital we maintain the 16 bed Mt. Airy House, numerous community outreach programs and the National Center for Human Development. For more than 100 years, Sheppard Pratt has earned its reputation for providing quality care to the chronically ill patient. And during these difficult economic times, we remain loyal to that heritage.

For further information or to make a referral contact the Adult Admissions Office at:
(301) 938-3800
6501 North Charles Street
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Stanley A. Klatsky, M.D. has been named president of the medical staff at Baltimore County General Hospital. Dr. Klatsky is an internationally recognized authority on aesthetic plastic surgery. He previously served as vice president and secretary-treasurer of the medical staff. He is currently the chief of the Division

of Plastic and Reconstructive Surgery, a position he has held since 1971.

Dr. Klatsky is past president and trustee of the American Society for Aesthetic Plastic Surgery (ASAPS) and is a member of the International Society for Aesthetic Plastic Surgery. He is the founding member and past president of the John Staige Davis Society of Plastic Surgeons of Maryland, as well as a founding member of the Northeastern Society of Plastic Surgeons. He currently serves on the American College of Surgeons' Plastic Surgery Advisory Council, and is a member of the American Society of Plastic and Reconstructive Surgeons.

A traveling professor for ASAPS, Dr. Klatsky served as co-chairperson for the First International Symposium of Aesthetic Surgery in Beijing, China. He has written extensively in numerous scientific journals and authored numerous chapters in plastic surgery textbooks.

Dr. Klatsky is an assistant professor in plastic surgery at The Johns Hopkins School of Medicine. Certified by the American Board of Plastic Surgery, he is a fellow of the American College of Surgeons and of the American Association of Plastic Surgeons. Dr. Klatsky received his plastic surgery training at the Columbia Presbyterian Medical Center in New York City.



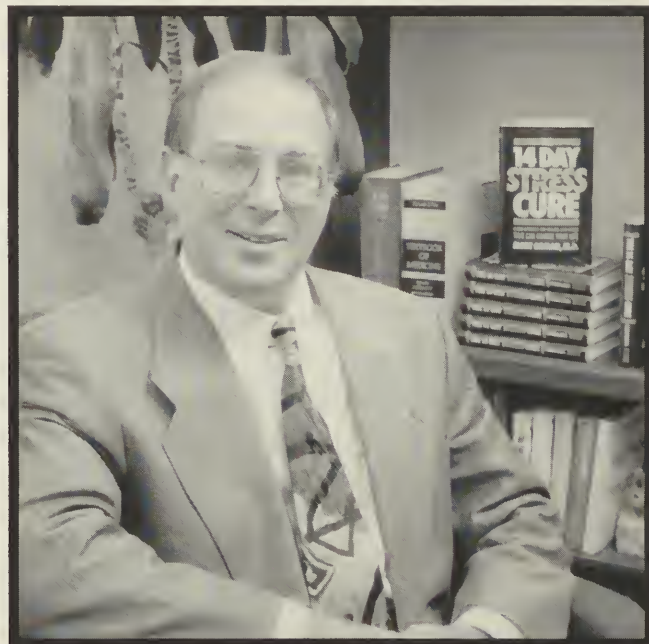
The Maryland Society of Eye Physicians and Surgeons (MSEPS) was recently honored as a model state society by the American Academy of Ophthalmology (AAO). *George S. Malouf, Jr., M.D.*, current president of MSEPS, received this award along with eleven other state societies that excelled in organization, political and public service projects for the year 1991. Each year, the Academy recognizes state societies that have achieved a level of excellence based on a legend of model state goals established by the AAO. These goals include sponsoring significant public information projects,

increasing its membership of practicing ophthalmologists, and promoting relations between ophthalmology and the rest of medicine. MSEPS was recognized at the AAO annual meeting in October.



Morton C. Orman, M.D., an internist in private practice in Baltimore, is the author of a new book published by Breakthru Publishing. In *The 14 Day Stress Cure*, Dr. Orman describes a step-by-step approach for getting rid of stress that does not require the use of drugs, relaxation exercises, or stress management techniques. He also debunks five key myths that are widely promoted by stress management experts but that actually keep people from dealing with stress successfully.

Medical director of the Catonsville Health Center (Care-First HMO) and director of the Behavioral Medicine and Biofeedback Referral Center in Baltimore, Dr. Orman graduated from Duke University and the University of Maryland School of Medicine. Specializing in treating stress



and stress-related disorders for more than a decade, he is the author of numerous articles, books and educational programs, and is the founder of the National Health Resource Network (a national, nonprofit organization to promote humanistic competence among health professionals). Married to a veterinarian (Christine Chambreau, D.V.M.), Dr. Orman has one daughter.



J. Leonard Lichtenfeld, M.D., an internist with an interest in medical oncology, was re-elected to serve a three-year



term as a trustee of the American Society of Internal Medicine (ASIM) during the Society's 35th annual meeting.

Certified by the Board of Internal Medicine in 1977, Dr. Lichtenfeld is on the staffs of Sinai Hospital of Baltimore, The Johns Hopkins Hospital, and the Baltimore County General Hospital.

He also is an instructor at The Johns Hopkins University School of Medicine. Dr. Lichtenfeld, who is involved in utilization review and quality assurance activities at the local and state level, is on the health advisory committee for U.S. Representative Ben Cardin, (D-Baltimore) and serves on the Reference and Appeals Committee of Blue Cross and Blue Shield of Maryland. In addition, Dr. Lichtenfeld hosts a weekly radio show on WCBM in Baltimore dealing with health issues.

Dr. Lichtenfeld, who received the Maryland Society of Internal Medicine's (MSIM) Internist of the Year award in 1987, is currently president of MSIM. An active Med Chi member, he has served on several Med Chi Committees and is active in numerous community organizations. He is a fellow of the American College of Physicians.

Dr. Lichtenfeld received his undergraduate degree from the University of Pennsylvania and his medical degree from Hahnemann Medical College in Philadelphia. ■

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TOUGH, SMART AND YOURS

medical
economics
A LITIGANT'S VIEW

Successfully defending a brain-damaged baby case is the courtroom equivalent of pitching a no-hitter. Because the "sympathy factor" can add millions to a jury's award, many insurance carriers would rather settle than fight.

Not so the P-I-E Mutual Insurance Co. of Cleveland, Ohio, and the 4-year-old law firm—Jacobson, Maynard, Tuschman & Kalur—that does all its defense work. In 21 brain-damaged baby cases it has defended for the last a remarkable 19-1-1, the last a hung jury. In 1988, its overall record read 34 wins, 5 losses—all malpractice cases.

There's more to those numbers than luck. "We even legal skill," adds JMT&K founding partner Aaron Jacobson, who was one of Ohio's leading plaintiffs' lawyers before he, Larry E. Rogers, Herbert S. Bell, M.D., and 70 other Cleveland doctors formed P-I-E in 1975.

"It's the concept behind the firm that makes it work. Physicians specially patch review every lawsuit to decide whether the defendant deviated significantly from the standard of care. If he did, we pay. If he didn't, we defend. Makes no difference whether it's a \$5,000 or a \$5 million case. We label it 'No pay.' That policy has resulted in a lot of cases being dropped. Perhaps more important, it's

DON'T YOU WISH THESE DEFENSE LAWYERS WERE YOURS?

This big, multistate firm rarely loses a case. But it's more than luck, or even legal skill, that's behind its enviable record.

By Howard Eisenberg

discouraged the filing of many other cases. Plaintiffs' attorneys have learned that we're fair negotiators when our doctor's in the wrong, but won't back down when he's right."

That approach pays off. "According to the most recent report I've seen from the General Accounting Office," says Larry Rogers, P-I-E president and CEO, "in 1984, about 57 percent of medical-malpractice claims were closed without payment. Through 1988, we've closed an average of 78 percent of our cases without a dime changing hands. And it's my understanding that, without including defense costs, St. Paul Fire and Marine Insurance Co.'s 1988 average gross payout for cases closed in Ohio with payment was \$52,300. Our comparable figure was about \$10,000 below

theirs. That's partly why we can sell an ORG specialty in Ohio—an industrial state that ranks among the most litigious—\$1.2 million in coverage for just \$26,400."

The unique marriage of P-I-E and JMT&K has been so successful that the carrier has expanded into five other states: Indiana, Kentucky, Maryland, Missouri, and West Virginia. Where P-I-E goes, there goes JMT&K, with nine branch offices to date. The firm has 64 trial attorneys, and may well be the nation's largest devoted well-high exclusive to medical-malpractice defense.

Could the insurer-defender symbiosis, if duplicated by other doctor companies, make a significant contribution to reducing malpractice litigation nationwide? An up-close look at

how JMT&K operates may help to answer that question.

Every lawyer develops a medical specialty

"Our firm's lawyers read more medical books than law books," says P-I-E Vice-President (and chief of counsel) Jerome S. Kalur, himself a veteran defense attorney. Robert Maynard explains, "Now cases are discussed at our weekly staff meeting, so that every lawyer is familiar with every case. But we assign cases to our attorneys according to medical specialty. They're well-versed in their fields, so they don't have to re-invent the wheel with each case." Last year, the firm's ORG specialist, attorney Jerome S. Kalur, who had won 18 consecutive brain-damaged baby cases, faced one of his toughest challenges when he defended a girl

who attempted a midforceps delivery that ended in a Caesar section and a severely brain-injured baby. Recalls Kalur, "I didn't think the doctor had caused the damage, but our position was weakened by the fact that he didn't have midforceps privileges. Based on that departure from the standard of care, our doctor panel voted to settle, and, since the hospital was also involved, a combined sum of \$1.5 million was offered. Plaintiffs turned us down flat."

"I wanted to depose the doctors who'd been involved in the mother's care during her hospitalization, but the attorney for the plaintiff baby insisted it would violate the mother's physician-patient confidentiality. That privilege would terminate automatically when her medical

The winning firm's four founders at Cleveland's 8th District Court of Appeals (from left) Jerome S. Kalur, Aaron Jacobson, James M. Tuschman, and Robert Maynard

records were introduced at the trial end of the plaintiff's case. Meanwhile, I was in the courtroom of having to tell the jury. It couldn't have been the midforceps, without offering them another reasonable brain damage theory."

Fortunately, the plaintiffs rested their case on a Friday afternoon, giving JMT&K time for a weekend rally. "Twenty minutes later," says Kalur, "I was in the hospital pathologist's office with an order permitting me to view the mother's placental slides." Maynard, Tuschman, and Kalur had been charted, and Kalur had a hunch that fetal distress had begun long before the fur-



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Legislative preview: An overview of legislative issues affecting Maryland medicine in 1992

Gerard E. Evans, Esquire

During the 1992 legislative session in Maryland, medicine will face a variety of issues, some old and familiar, and others that bring new challenges. The following is a list of what Med Chi can expect to encounter.

HIV protocol

In response to a request from the legislature, Med Chi developed a practice protocol for physicians with HIV which has been approved by Council. It was presented to the legislature in December. The protocol provides anonymity for infected physicians, while guaranteeing safety to the public.

Med Chi opposes mandatory testing of physicians and other health care workers, citing the Center for Disease Control (CDC) guidelines as an established and effective way to protect both patients and health care workers.

Although the public sentiment in favor of mandatory testing seems to be growing, the governor's own AIDS Advisory Council has recommended against mandatory testing of health care workers. Mandatory testing would cost several million dollars per year without any real benefit to the public.

Tobacco and alcohol use

Tobacco and alcohol use have been increasing steadily in the ranks of the young. Surgeon General Novello released a report this summer stating that eight million junior and senior high school students use alcohol weekly. In response to this trend, Novello and National Drug Control Policy Director Bob Martinez have

expanded their goals to include reducing the amount of advertising of tobacco and alcohol to young people.

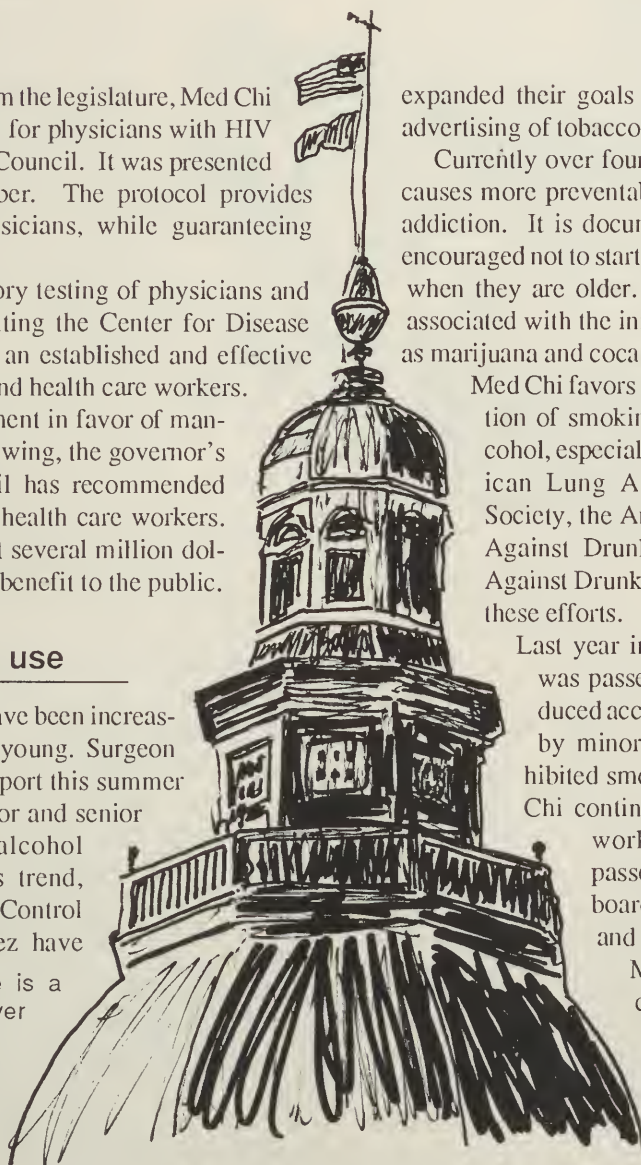
Currently over four million teenagers smoke. Smoking causes more preventable illnesses than any other form of addiction. It is documented that if young people can be encouraged not to start smoking, they probably will not start when they are older. Alcohol and tobacco use are also associated with the initiation of other illicit drug use, such as marijuana and cocaine.

Med Chi favors all legislation encouraging the cessation of smoking and a reduction in the use of alcohol, especially among teenagers. With the American Lung Association, the American Cancer Society, the American Heart Association, Mothers Against Drunk Driving (MADD), and Students Against Drunk Driving (SADD), Med Chi supports these efforts.

Last year in Maryland, a bill taxing cigarettes was passed. But a bill which would have reduced access to cigarettes in vending machines by minors and one which would have prohibited smoking in public were defeated. Med Chi continues to support these bills and will work to have them resubmitted and passed. Med Chi will suggest that billboard advertisements for both alcohol and tobacco be curtailed.

Med Chi would also like to express its concern regarding the curtailing of counseling services for alcohol and drug addiction, especially at the state hospitals, which have been severely hit by the budget cuts.

Gerard E. Evans, Esquire is a partner in Rifkin, Evans, Silver and Rozner and serves as chief lobbyist in Annapolis for the Medical and Chirurgical Faculty of Maryland each legislative session.

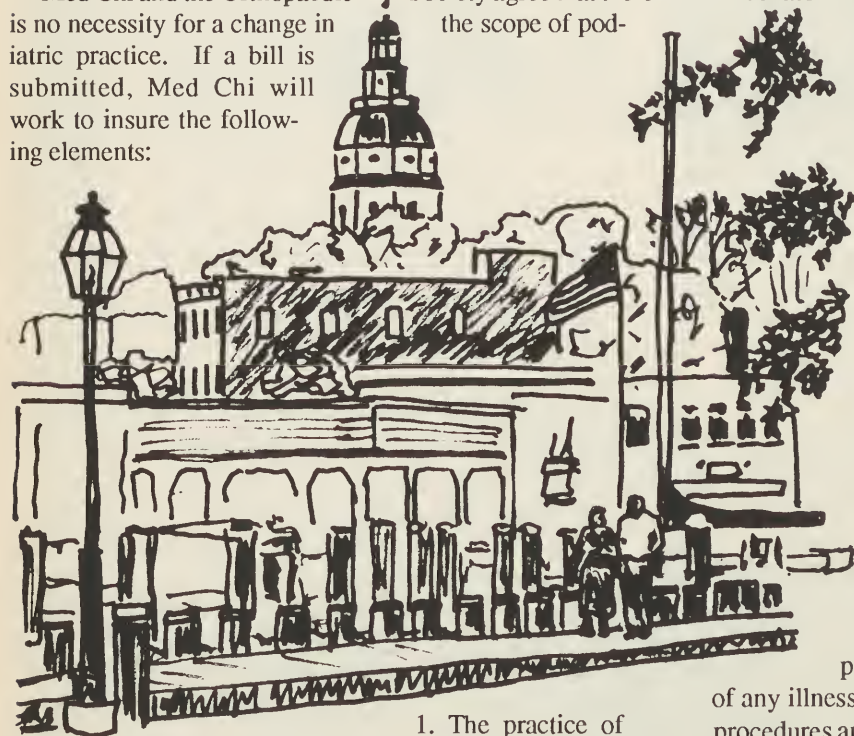


Podiatry bill (SB 428 - 1991)

The Maryland Orthopaedic Society and the Maryland Podiatric Medical Association have again been discussing the scope of podiatry practice with Senator Paula Hollinger (D., Baltimore County - 11th district) and Senator Virginia Thomas (D., Howard County). The purpose of last year's bill was "to alter the definition of podiatry to include the capability of a licensed podiatrist to diagnose and surgically, medically, or mechanically treat any ailment of the human ankle and certain other related structures..."

This bill does not represent a turf battle as indicated by some, but rather a genuine concern regarding the quality of care provided to the citizens of Maryland.

Med Chi and the Orthopaedic Society agree that there is no necessity for a change in the scope of podiatric practice. If a bill is submitted, Med Chi will work to insure the following elements:



1. The practice of podiatry will not include administration of an anesthetic, other than a local anesthetic; arthrodesis of two or more tarsal bones; complete tarsal osteotomy, open or closed reduction of ankle fractures; ankle arthrodeses; or the repair of chronic lateral ankle instability.
2. A licensed podiatrist may only perform surgical procedures on the ankle if he/she has completed a three-year in-hospital surgical residency.
3. There will be no grandfathering of podiatrists currently practicing in the state.
4. Surgical procedures must be performed in a licensed hospital, not a free-standing center.

Med Chi and the Orthopaedic Society feel there is no need for a bill to change the scope of podiatric practice. However, if a bill is submitted, Med Chi will oppose any bill that does not include the above stated elements. The medical community understands the desire and the interest of the Podiatric

Medical Association to increase the scope of podiatric practice, but any increase must insure the current standard of care for the citizens of Maryland. Currently, most podiatrists have no hands-on postgraduate training. For the protection of the patient, it is imperative that those who provide care have completed the proper training and are qualified to perform surgical procedures. It is also essential that these procedures be performed in a hospital with ongoing quality assurance and utilization review.

Universal Health Insurance for Maryland

Senator Hollinger strongly feels that every citizen in the state should have access to medical care. She has therefore drafted legislation to create the Universal Health Insurance for Maryland (UHIM) plan, its governing structure, and its coverage. This bill would mandate a basic policy for every citizen in the state. This bill is clearly a single-payor approach to universal access. Administration of the plan would be by a Board of Governors consisting of 20 members appointed by the governor and approved by the Senate.

Non-state residents working in Maryland who pay a payroll deduction would also be eligible during any period of employment. Pre-existing conditions would not exclude eligibility.

The first ten days of inpatient hospital stay and related professional services, whether for physical or mental illness, would be covered.

Ten office visits with a licensed health care provider per year for the diagnosis and treatment of any illness or injury, including laboratory and diagnostic procedures and outpatient surgery, would also be covered, as well as reasonable prenatal and newborn child care. The policy would contain an exclusion for services that are not medically necessary or are not covered under preventive health services. The reimbursement for hospital rates would be determined by the Health Systems Cost Review Commission (HSCRC). Outpatient rates would be determined by the Board of Governors—probably based on Medicare's resource-based relative value scale (RBRVS).

To fund this program, Medicare/Medicaid would pay directly into the fund (a capitated fee plus an adjustment for nonpaying residents, i.e., the unemployed). There would also be a payroll deduction for all workers and dependents to be set by the Board of Governors, which would also include an additional adjustment for nonpaying residents. There would be a state affordability cap as set by the Board of Governors on the total amount in the fund. Providers would be prohibited from charging rates for covered services that exceed the rates set by UHIM.

No position has been taken at this time regarding this bill, but Med Chi favors the AMA's Health Access America plan as a more workable solution to the health care crisis.

There are several areas of concern regarding this bill:

- The Board of Governors is quite large (20 members), with an extraordinarily small representation of the medical providers of this state.
- Maryland has a strong existing all-payor system, so there are cogent arguments for staying with the all-payor system rather than a single-payor system for outpatient services and an all-payor system for inpatient services. There is also concern over the language regarding managed care provisions.
- Tying reimbursement to RBRVS when it has not even had a trial with Medicare seems to be very risky. Although the plan allows for the purchase of enhancement policies, it appears that fees may be capped at RBRVS levels, making the purchase of an additional policy questionable.

Fee capping issues

During the 1991 session, there was much effort to initiate studies by the HSCRC regarding the regulation of hospital-based physicians. The Maryland Chamber of Commerce was instrumental in introducing several of these bills. This year, the effort may be even stronger because the Maryland Chamber of Commerce and the Maryland Economic Growth Associates (MEGA) have merged. Former Baltimore County Executive Don Hutchinson has assumed the Chamber presidency after heading up MEGA for the past four and a half years. Mr. Hutchinson remains a powerful political figure in the Maryland arena and will definitely add clout to the Chamber's efforts.

The federal government and many insurance companies have already conducted studies indicating that Maryland physicians' fees are not above average nationally. At the federal level, regulation of physicians' fees has increased greatly in the past several years and at the local level, many hospital-based physicians' fees are regulated by contractual agreement. Considering the extent of the budget deficit, Med Chi believes another study is not warranted and that the little that might be learned from such a study would not warrant its cost.

The HSCRC exists in this state in order to prevent the loss of the diagnostic related group (DRG) waiver for Medicare and to preserve the "all-payor system," not to regulate health care providers. Also, HSCRC regulation of radiologists, anesthesiologists, and pathologists (RAPs) was overturned several years ago by the courts in a case involving Holy Cross Hospital. Greater regulation would encourage physicians

working within hospitals to move their services outside of the hospital environment, and may be even out of the state. This would affect the stability of the state's hospitals, as well as creating an access problem for patients.

Mandated Medicare Assignment

For the last five years, Delegate Pinsky (D., Prince George's County) has attempted to institute Mandated Medicare Assignment in Maryland. Last year, he introduced legislation that would prohibit any physician, not just emergency room physicians, who provides emergency medical care to Medicare beneficiaries in hospital emergency rooms in Maryland from charging any amount in excess of the charge for that service as determined by the United States Secretary for Health and Human Services.

We assume that he will again introduce legislation mandating assignment in spite of the fact that more than 88 percent of the claims filed in Maryland in 1990 were accepted on an assigned basis and 41 percent of the physicians in Maryland are now participating physicians.

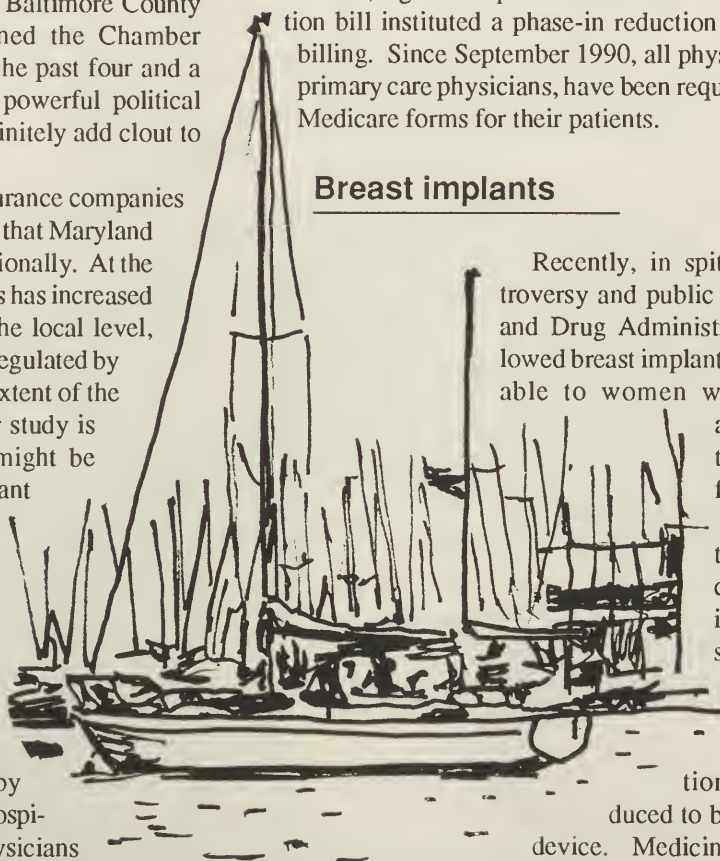
Medicare fees are already controlled at the federal level through reimbursement regulations. Mandated Medicare Assignment has been strongly defeated at the federal level because federal legislators feel it is a constraint of trade and that the RBRVS will replace the current system as of January 1, 1992. This remains a federal issue not a state issue; it should be handled at the federal level.

Also, legislation passed in the 1990 Budget Reconciliation bill instituted a phase-in reduction plan for balance billing. Since September 1990, all physicians, including primary care physicians, have been required to fill out the Medicare forms for their patients.

Breast implants

Recently, in spite of much controversy and public outcry, the Food and Drug Administration (FDA) allowed breast implants to remain available to women who need breast augmentation. Although much information has been reviewed, there is no conclusive proof that implants are unsafe.

It is apparent that state legislation will be introduced to bar the use of this device. Medicine will scrutinize



closely any attempt to restrict its authority until real evidence exists about possible dangers.

As in past years, the issues affecting medicine are

many and varied. Med

Chi will be active

in Annapolis, con-

tinuing medi-

cine's struggle to

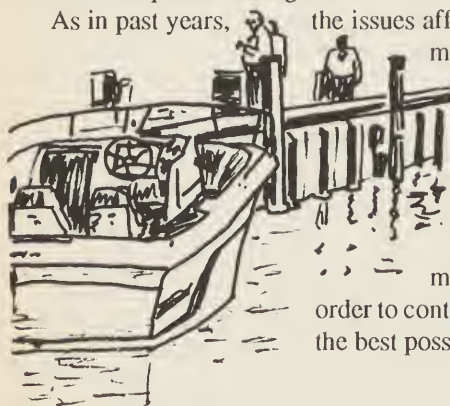
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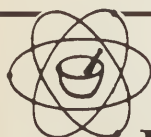


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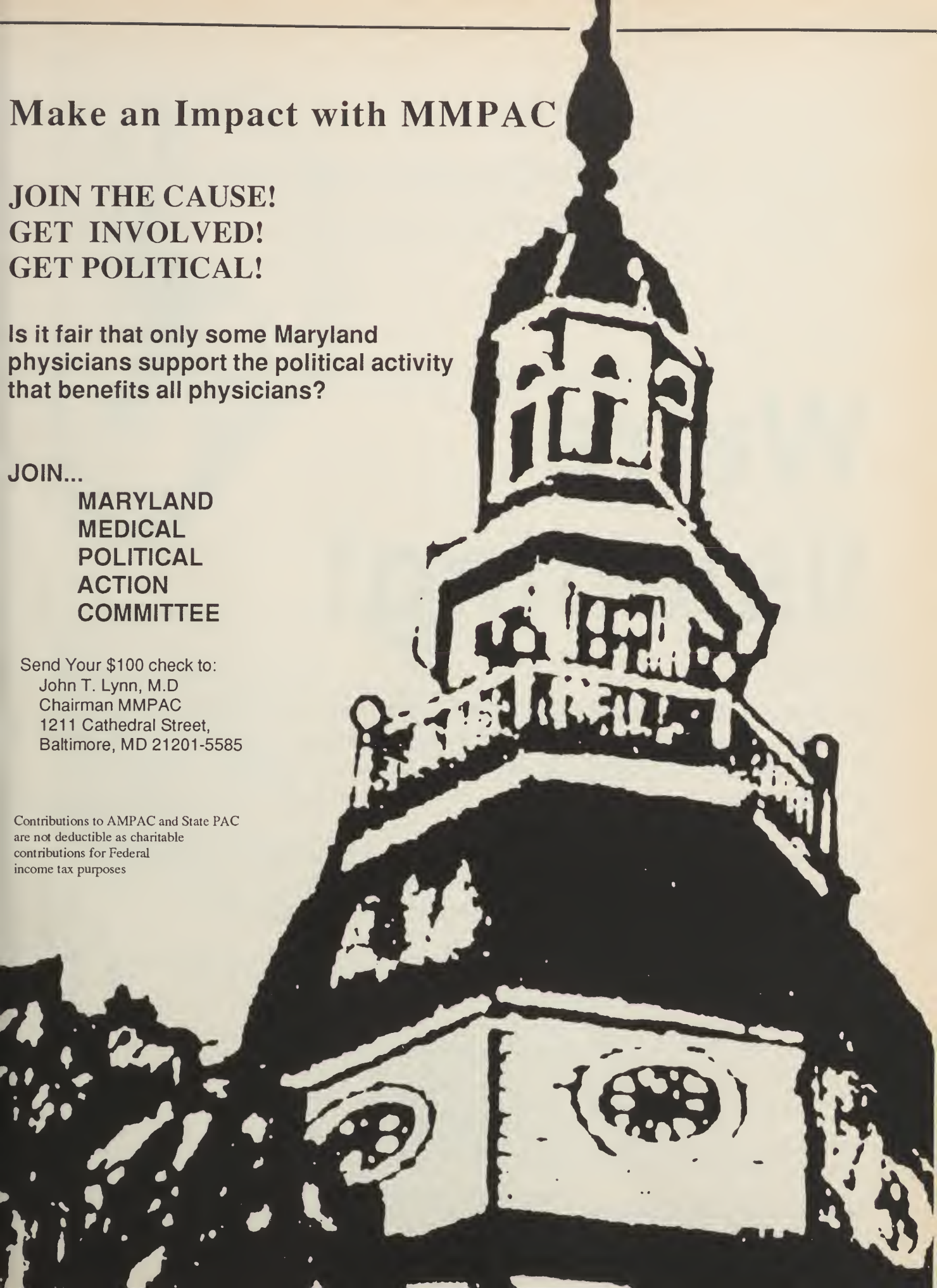
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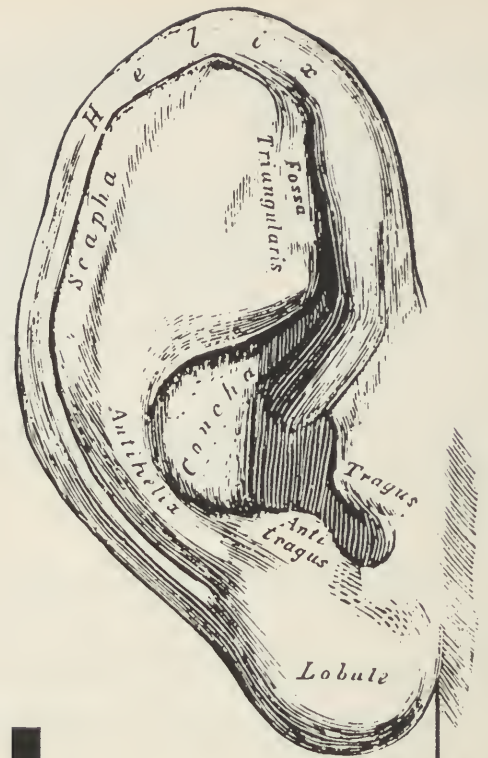
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Providers with HIV/AIDS — A new dilemma

Katherine Karker-Jennings, Esq. and Michael F. Berkey, Esq.

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Recently, a great deal of attention has been focused on health care providers who have or may have the human immunodeficiency virus or, as it is known in its later stages, acquired immunodeficiency syndrome. This article explores some of the duties physicians have, or soon may have, to their patients and employers in the areas of testing, disclosure, and practice restraints.

Two recent cases involving health care providers afflicted with acquired immunodeficiency syndrome (AIDS) have brought to light a new dilemma: What duties do providers owe to employers and patients with respect to testing, disclosure, and modification of medical practice when they have, or suspect they might have, AIDS?

In the first case, Mrs. Perry Rossi agreed to have Dr. Rudolph Almaraz, a surgeon at The Johns Hopkins Hospital in Baltimore, Maryland, remove a nonmalignant lump from her breast. Dr. Almaraz performed the operation in November 1989, one of the 1,800 operations he had performed since joining the hospital in 1984. The case would probably have gone unnoticed among the thousands of such operations performed nationwide each year except for one detail — Dr. Almaraz died of AIDS one year later, and only after his death did his estate and the hospital disclose the fact that Dr. Almaraz had suffered from AIDS while still performing surgery. Shortly thereafter, without yet knowing whether she had contracted the disease, Mrs. Rossi filed a \$32 million lawsuit against the hospital and the doctor's estate.¹

The second case involved Dr. David Acer, a Florida dentist who recently died of AIDS. Dr. Acer, who had continued to practice after being diagnosed with AIDS, wrote an open letter to his patients urging them to be tested for the human immunodeficiency virus (HIV) after learning that he might have infected 19-year-old Kimberly Bergalis during the extraction of her wisdom teeth in 1987. Another tragedy, another lawsuit; this one settled for \$1 million.² After subsequent testing, two more patients of Dr. Acer have turned up HIV-positive, also apparently resulting from dental procedures he performed.³

Whenever undesirable events occur, it is natural to seek their cause as the first step toward preventing their recurrence. It is also natural to place

the blame for the events on someone other than the one who has suffered the harm. This is the premise for the law of negligence, with its four familiar aspects of duty, breach, injury, and causation.

Much of the development of the law of HIV/AIDS, indeed much of the development of American tort law in general, consists of recognizing, pursuing, or creating new duties, which may then be (or already have been) breached. Duties may be established by statute, or they may simply evolve based on the changing standards of care common and accepted in a particular community, whether that be the patient community or the medical community of providers, or both.

In the first few years of the HIV/AIDS "crisis," the focus was on patients who might have the disease and whether persons in certain situations had duties to test or be tested, to disclose or warn, and to modify their behaviors or refrain from certain activities. Only recently, largely as a result of the cases of Drs. Acer and Almaraz, has the public (including providers, patients, lawyers, and legislators) begun to direct its attention to health care providers with HIV/AIDS.

It is difficult to tell whether the cases of Drs. Acer and Almaraz are symptomatic of a larger problem or merely aberrations in an otherwise safe environment. However, it has been estimated by the Centers for Disease Control (CDC) that 128 Americans have been infected with HIV by surgeons or dentists to date,⁴ and the history of the United States' response to HIV/AIDS suggests that this number will be treated as unacceptably high.

A number of complicated legal issues emerge from these two cases. For example: What obligations do providers of health care owe the patient population? What are the different interests at stake in deciding whether to mandate testing of providers for HIV infection? Would disclosure of the results of HIV testing be desirable? What changes should be made in a provider's practice when he or she is known to be infected with HIV? More questions are bound to arise in the near future, as only a rapidly discovered cure or vaccine for HIV/AIDS is likely to slow the almost frenetic pace of litigation and legislation this disease has engendered.

This article will first review the evolution of duties that have been directed at *patients*, and then focus on the potential duties of *providers*, with respect to the following three questions:

1. What is the duty to be *tested* for HIV?
2. To whom is there a duty to *disclose the results* of HIV testing?
3. To what extent is there any duty to *modify behavior* when one has tested positive for HIV?

Current duties of patients

Before debating the pros and cons of testing providers, and then further debating what to do about the test results, it is instructive to review the duties to test, to warn, and to refrain from certain high risk activities that have evolved with respect to *patients*.

Mandatory testing

Situations requiring testing or imposing a duty to test may be viewed as exceptions to the general rule that informed consent must be obtained before the individual's privacy may be invaded with a needle. As of 1990, about one-third of the states had statutory or regulatory exceptions to the informed consent doctrine, usually involving testing following potential exposure to health care workers and/or emergency medical personnel.⁵ In addition, almost one-half of the states have enacted laws that make HIV testing compulsory for prostitutes and other sex offenders.⁶

Despite the nationwide presence of informed consent laws, which generally have very limited exceptions, the trend among physicians, here and abroad, is to demand HIV testing of *all* patients being admitted to a hospital for surgical or other procedures,⁷ and, in reality, such testing may already be the normal (yet improper) practice of many hospitals.⁸ To meet the desire of hospitals and physicians to require HIV testing upon hospital admission, however, many states have begun to draft such statutes for debate in the 1991 legislative year.⁹

Permitted or required disclosure

A number of different types of notification statutes exist with respect to communication of an individual's HIV status to a third party. Ten states have legislation or regulations that allow notification to blood donors;¹⁰ 17 states allow notification to known sexual partners;¹¹ 19 states require notification to emergency medical personnel;¹² 27 states require notification to health care workers;¹³ and 17 states require notification to funeral directors.¹⁴

Compulsory behavior modification

Many states have enacted criminal and/or civil statutes to help control high risk behavior in confirmed HIV-positive individuals. In Maryland, for example, an HIV-positive individual who willfully, knowingly, and intentionally transfers or attempts to transfer the disease to another individual is guilty of a misdemeanor and can face a fine of up to \$2,500 or imprisonment for up to three years, or both.¹⁵ In California, a prostitute convicted of a second offense after previously testing positive for HIV (a test that is required upon a first conviction) is guilty of a felony.¹⁶ Similarly, Mexico recently introduced a new law calling for jail sentences of up to five years for anyone found guilty of knowingly transmitting an incurable disease through sexual contact, and up to three years for knowingly spreading a curable sexually transmitted disease.¹⁷

Potential duties of providers

Even before the cases of Drs. Acer and Almaraz were publicized, at least one author had argued that the justifications for and against screening patients and providers were "symmetrical."¹⁸ Although that may be true in theory, in practical terms, it would be difficult to implement the same

duties with respect to providers as have been imposed on patients. Providers, as a group, are more politically astute and organized than are patients, and the types of duties already imposed on patients are not easily translated into duties that can be conferred on providers.

Mandatory testing

One area where there *is* symmetry between patients and providers is mandatory testing. Thus far, mandatory testing for both patients and providers is the exception, not the rule, not because there is no need or desire to test, but because of the issue of reliability. The most common form of current testing is inconclusive, since it discloses only the antibodies produced to fight HIV, and these antibodies usually cannot be detected until at least six to fourteen weeks, and sometimes years, after infection, during which time the infected in-

dividual could have been infecting others.¹⁹ Moreover, test results are not 100 percent accurate, nor are they accurately read 100 percent of the time.²⁰ These factors combine to make reliance on antibody testing inappropriate for providers when career-sensitive decisions must be made.

More reliable is a genetic test that can detect HIV itself, but it is very expensive to perform.¹⁹ Where the need or desire to know the HIV status of providers is considered great, however, the cost of this type of testing might be justified. At some point, the determination may be made that the risk of providers transferring HIV to patients is unacceptably high, and that such alternatives as universal precautions (which are based on the assumption that either the patient or the provider already has HIV) provide insufficient protection. When that time comes, genetic testing may become a duty of the provider.

Although less expensive and more accurate tests may be developed in the future that would increase the likelihood of imposing a duty of mandatory testing on providers, especially those who perform procedures involving blood or bodily fluids, no such duty is likely to be found at this time. Meanwhile, providers may find that the fourth amendment's prohibition against unreasonable searches and seizures provides additional insulation from mandatory HIV testing. In the leading case on this subject from the perspective of health care workers, *Glover v Eastern Nebraska Community Office of Retardation*,²¹ the Eighth Circuit Court of Appeals affirmed a lower court holding that testing certain health care workers was unconstitutional. In striking down policy implemented by a facility for the mentally retarded for HIV screening of staff members where such staff members came in direct contact with patients, the lower court had said, "[t]here is simply no real basis to be concerned that clients are at risk of contracting the AIDS virus at the work place."²²

Required disclosure

Both the American Medical Association (AMA) and the American Dental Association (ADA) issued recommendations in January 1991 that urged providers infected with HIV to warn patients about their condition.²³ The CDC, which had previously recommended only voluntary disclosure to a provider's employer, was expected to issue a revision to its recommendations for providers later in the

Physicians and HIV: An update for Maryland physicians

The Maryland General Assembly addressed the problem of HIV-infected physicians and passed H.B. 124 in May 1991. This law charged the Medical and Chirurgical Faculty of Maryland (Med Chi), in consultation with the Centers for Disease Control (CDC), the Maryland Hospital Association and the Department of Health and Mental Hygiene, to develop a practice protocol for HIV-infected physicians. This protocol was passed by the Med Chi House of Delegates in September and was presented to the Maryland legislature in December 1991. (See *MMJ* 1991; 40(12): 1128-9.)

During the development of this protocol, Governor Schaefer announced in August that he was considering pursuing mandatory testing for HIV for health care workers and patients. Following this announcement, Med Chi issued a news release reaffirming its opposition to mandatory HIV testing for health care workers and patients.

Citing lack of scientific evidence for the need to test health care workers and the exorbitant increase in health care costs that would result from testing health care workers and patients, Med Chi reiterated its position in its practice protocol for HIV-infected physicians. The protocol is based, in part, on CDC guidelines which do not recommend mandatory testing for health care workers or patients. The Med Chi protocol recommends voluntary testing of physicians who perform exposure-prone invasive procedures or procedures at high-risk for transmitting HIV. If the protocol becomes Maryland law, HIV-infected physicians would report to a panel of experts who would evaluate them and set limits on their practices.

Med Chi is currently undertaking a campaign to educate physicians and the public about the real risks of HIV transmission. Part of the campaign is a series of letters to legislators providing data on HIV transmission in Maryland, as well as on the costs and potential consequences of a mandatory testing program.

At press time (November 15, 1991), no information was available regarding the governor's proposed testing program. However, Med Chi anticipates that a bill requiring mandatory testing of health care workers and patients will be introduced during the 1992 session.

"The physicians of Maryland hope legislators will consider the scientific facts when voting on any legislation relating to mandatory testing of health care workers for HIV," said Med Chi Council Chairperson Marvin Schneider, M.D. in response to Schaefer's announcement in August. "Med Chi believes that only through the application of sound medical principles will society be able to confront this disease rationally and compassionately, and thus ensure the safety and health of all our patients."

year.²³ Recommendations from such official sources are tantamount to establishing a duty to disclose HIV infection to patients, even though most patients would choose not to obtain further care from an infected provider.^{3,24}

Even without such official pronouncements, however, "hospital policy" may be sufficient to require a provider to disclose his or her HIV status to an employer hospital or face termination or loss of privileges. This principle is well illustrated by one recent case, where a nurse was encouraged by his employer hospital's infection control practitioner to have an HIV test when it came to the attention of the hospital that the nurse's roommate was an AIDS patient.²⁵ When approached by the infection control practitioner, the nurse said that he had already been tested and promised to supply the results to the hospital when they became available. In addition, he volunteered the fact that he had a draining cyst under his arm. The nurse was then told not to return to work until he was cleared by a doctor.²⁵

After the nurse received the test results, he refused to disclose them to the hospital, and the hospital, which had already learned that the nurse had tested positive for hepatitis B and had a history of syphilis, fired him.²⁵ This termination was upheld on appeal to the Fifth Circuit Court of Appeals, which held that the nurse's failure to comply with a hospital disclosure policy designed to safeguard the health of patients justified the hospital's action.²⁵ The consequences to a health care provider of disclosing an HIV-positive test result, and the court's possible reaction to termination based on this disclosure, were not discussed, but it seems likely that, if a termination decision for nondisclosure can be upheld, termination for being HIV-positive (the worst possible disclosure) would also be considered justified, even in the face of laws designed to protect the handicapped.²⁶ Court cases involving HIV/AIDS often turn on the particular facts, but it is still difficult to reconcile the Fifth Circuit's conclusion in this case with the Eighth Circuit's holding in *Glover*.^{21,22}

Compulsory behavior modification

At present, the decision whether or not to continue to practice after being diagnosed with HIV or AIDS rests solely with the health care provider. However, both the AMA and ADA recommend that providers with HIV/AIDS abandon surgery altogether unless their patients are fully informed of the provider's condition and the risks of HIV transmission, and thereafter consent to such procedures.²⁴ Although any pronouncements by such nationally recognized organizations significantly increase the likelihood that an enforceable duty to comply will be created, they are not binding. In fact, New York State health officials have specifically decided not to mandate a duty of informed consent or behavior modification by regulation, maintaining that the risk to patients from providers is too small to warrant such action, especially where precautions are taken against transmission.³

Other possible alternatives to informed consent by HIV-infected surgeons would be simply to ban certain classes of

providers, such as surgeons, from continued practice if they are HIV-positive, or to restrict the procedures that HIV-infected providers may perform, either by employing a subjective general definition of prohibited procedures or objectively listing those procedures that are forbidden.^{18,27} Providers or procedures not covered by the ban would still be subject to the informed consent duty.

Conclusion

In the past, physician rights and patient duties with respect to HIV/AIDS came under scrutiny only when the perceived danger was HIV transmission from patient to physician. Now that it is apparent from the cases of Drs. Almaraz and Acer that the transmission arrow may point in both directions, patient rights and concomitant provider duties must be analyzed.

While it is apparent that Drs. Almaraz and Acer eventually realized that they were infected with HIV, it is unclear when either doctor first became aware of his illness, and it therefore cannot be stated with any certainty that mandatory testing (even if totally accurate and conclusive) would have changed the outcome of either case. At this juncture, mainly because of the fallibility of antibody testing (and, arguably, the high cost of genetic testing), mandatory HIV testing of providers has not yet been embraced by the medical community, the legal community, or the government.

Once a provider is aware that he or she is HIV-positive, however, the more problematic issue of disclosure comes into play. Courts appear to be split over whether such a duty exists, and various state legislatures are just now beginning to grapple with the problem.

With regard to behavior modification, absent disclosure to the patient, the decision presently rests solely with the provider as to whether or not he or she will continue to perform "invasive procedures." With disclosure, the patients themselves will dictate, through informed consent (or refusal), the procedures permitted by HIV-infected providers.

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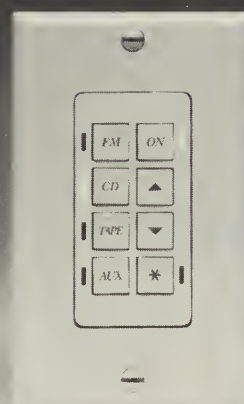
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11. See, e.g., Ga Code Ann. §24-9-47 (1988).
12. See, e.g., La Rev Stat Ann. §40: 1099A (West 1988).
13. See, e.g., NM Stat Ann. §24-2B-5 (1989).
14. See, e.g., Mich Comp Laws Ann. §333.2843b (West 1986).
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25. Leckelt v Board of Comm're of Hosp Dist No 1, 909 F.2d 820, 822-24, 833 (5th Cir 1990).
26. See, 29 U.S.C. §794 (1988).
27. Any subjective definition used would have to be more descriptive than the phrase "invasive procedure" or "seriously invasive procedure," but less broad than the phrase "any procedure where transmission of HIV is possible." ■

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The legislative process*

From hopper to enactment

The drafting of legislation requires the skill of experienced and trained personnel. This service is rendered by the Department of Legislative Reference. A bill or joint resolution may be introduced in advance of regular sessions and is styled a "prefiled bill." A bill is filed (is dropped into the hopper) with the secretary of the Senate or the clerk of the House, is given a number, and is readied for its first reading on the floor. Bills may be introduced in either chamber until the last 35 days of the session. After that, bills may be introduced only with the consent of two-thirds of the membership.

First reading. The reading clerk, when the session has convened, reads the title, and the presiding officer assigns the bill to the appropriate committee.

Reference to committee. The committees meet daily during the session to receive testimony and take action on bills assigned. Citizens are encouraged to present their views on the subject matter by mail or by personal appearance. Legislative agents (lobbyists), representing organized interest groups, speak at these hearings, either to oppose or support the proposed legislation. The Department of Fiscal Services prepares a fiscal analysis for each bill and these fiscal notes are considered during the committee deliberation.

Unfavorable committee action, which may mean legislative death, frequently requires as much, or more, committee discussion and time as favorable committee action, which sends the bill to the floor for second reading and floor consideration.

Second reading and floor consideration. The bill is reported to the floor by the committee (favorably, unfavorably, or without recommendation, and with or without committee amendment). It is open to amendment from the floor, and the ultimate form of the bill must be determined on second reading. Committee action may be reversed but this is infrequent.

Third reading. The bill must be printed for third reading with all amendments included in this final version. No amendments may be presented on third reading in the chamber of its origin, and the bill must be passed by a majority of the elected membership.

Second chamber. The procedure follows a pattern identical with that of the chamber in which the bill originated, except amendments may be proposed during third reading as well as second reading. If not amended in the second chamber, final passage may occur without reprinting.

Consideration of bills*

Consideration of bills originating in one chamber and amended in second chamber

If amended in the second chamber, the bill is returned to the chamber of origin where a vote is taken on a motion to concur or reject the amendments. If concurrence is voted, the bill itself is voted on as amended and action is complete. The bill is reprinted, or enrolled, to include the added amendments before submitting it to the governor.

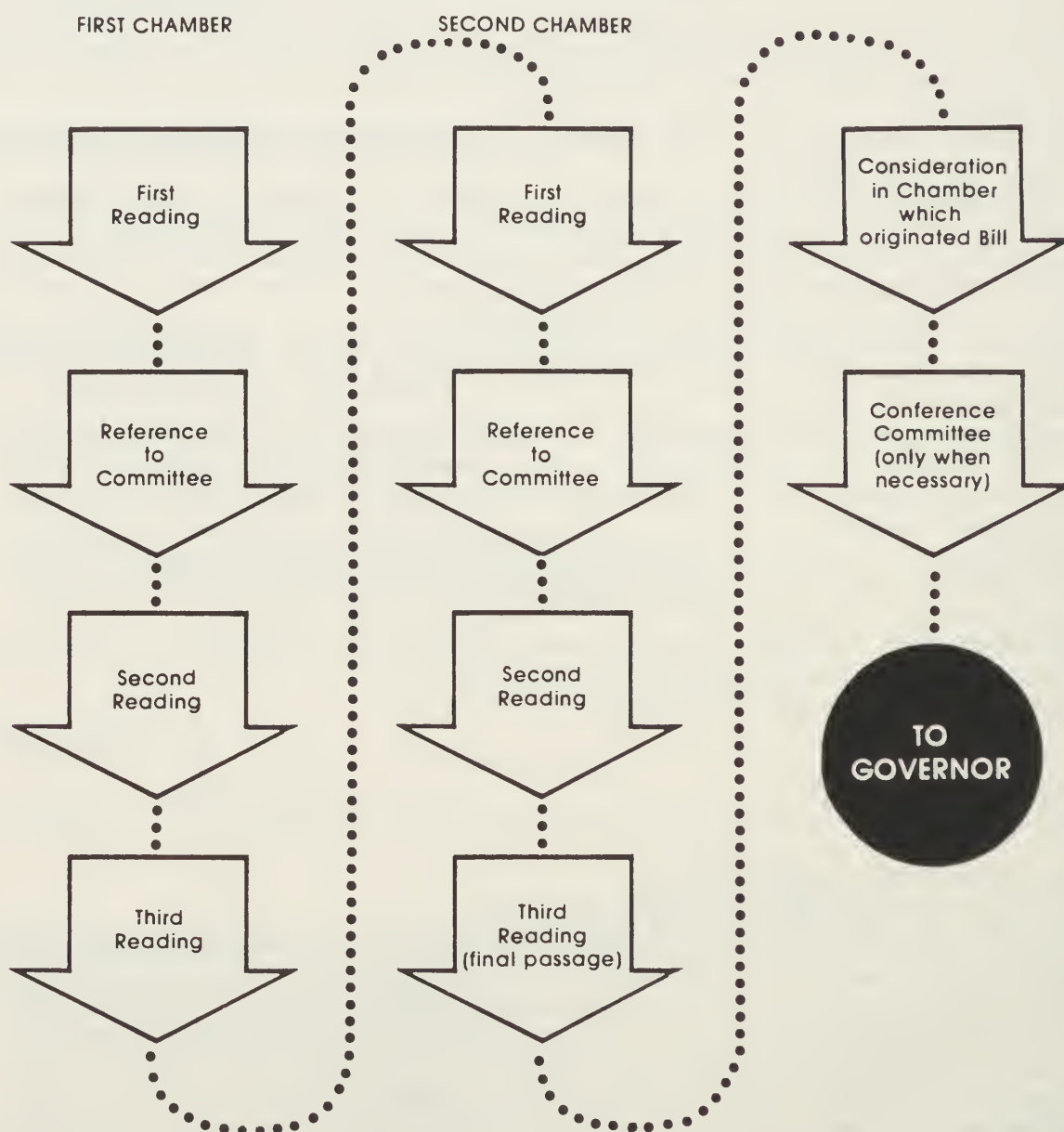
If the amendments are rejected, two courses of action are possible: (1) the amending chamber may be requested to withdraw its amendments or (2) upon refusal of withdrawal of amendments, either chamber may request a conference committee to resolve the differences between the two chambers.

Conference committee. A report of a conference committee goes back to both chambers to be adopted or rejected without amendment. If the conference committee report is adopted, the bill is voted upon for final passage in each house. If the conference committee report is rejected by either house, the bill fails.

Presentation of bills to the governor. Presentation of all bills to the governor is mandatory, except the budget bill and constitutional amendments. The budget bill becomes law upon its final passage and cannot be vetoed. Bills must be presented to the governor within 20 days following adjournment of a session, and in the case of such bills, the governor may veto within 30 days after presentation to him. If a bill is not vetoed, it becomes a law. The governor may not veto a constitutional amendment.

The power to override a veto. This power rests with the legislature. If a bill is vetoed during regular session, the veto message is considered immediately. If a bill presented after the session is vetoed, the veto message must be considered immediately at the next regular or special session of the legislature, except that the legislature may not override a veto during the first year of a new term. A three-fifths vote of the elected membership in each chamber is necessary to override a veto.

The progress of a bill*



* Information for this and the preceding page was provided by the State of Maryland Department of Legislative Reference, F. Carvel Payne, Director.

The 1992 Maryland General Assembly — Dates of interest

January 8	Session convenes.
January 15	Budget must be submitted by governor prior to this date.
January 21	Senate bill and House bill request guarantee date. (All bills filed by this date <i>must</i> be considered by committee.)
January 31	Senate bill and House bill introduction date. (Senate bills introduced after this date are referred to the Senate Rules Committee.)
February 21	House bills introduced after this date are referred to the House Rules Committee. (They are not guaranteed to have public committee hearings.)
March 17	Committee reporting courtesy date. Committees in each chamber should report out those bills they intend to pass favorably by this date.
March 23	Opposite chamber bill crossover date. The first chamber should pass those bills requiring consideration by the opposite chamber by this date.
March 30	Budget bill to be passed by both chambers by this date.
April 6	Adjournment.

The 1992 Maryland General Assembly — Important telephone numbers

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Legislative information & library	ext. 3810	Office of the Speaker of the House of Delegates	ext. 3800
Information desk, State House	ext. 3886	House majority leader	ext. 3534
Office of the President of the Senate	ext. 3700	House minority leader	ext. 3401
Senate majority leader	ext. 3697	House Committee on Appropriations	ext. 3407
Senate minority leader	ext. 3568	House Committee on Constitutional and Administrative Law	ext. 3502
Senate Budget & Taxation Committee	ext. 3690	House Committee on Economic Matters	ext. 3519
Senate Economic & Environmental Affairs Committee	ext. 3661	House Judiciary Committee	ext. 3488
Senate Finance Committee	ext. 3677	House Committee on Ways and Means	ext. 3469
Senate Judicial Proceedings Committee	ext. 3623	Bill room (copies of bills, amendments, and fiscal notes)	ext. 3840

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Del. Frank D. Boston, Jr.	314 House Office Bldg. Annapolis 21401 ext. 3283	2200 Garrison Blvd. Baltimore 21216 410-566-3373	41	Baltimore City	5
Del. Margaret H. Murphy	314 House Office Bldg. Annapolis 21401 ext. 3283	4811 Liberty Hgts. Ave. Baltimore 21207 410-367-5811	41	Baltimore City	13
Del. Samuel M. Parham	314 House Office Bldg. Annapolis 21401 ext. 3283	4811 Liberty Hgts. Ave. Baltimore 21207 410-367-7455	41	Baltimore City	3
Sen. Barbara A. Hoffman	100 Senate Office Bldg. Annapolis 21401 ext. 3648	6615 Reisterstown Rd. Suite 301 Baltimore 21215 410-764-3614	42	Baltimore City	8
Del. James W. Campbell	320 House Office Bldg. Annapolis 21401 ext. 3297	1329½ W. 41st St. Baltimore 21211 410-366-8160	42	Baltimore City	13
Del. Delores G. Kelley	320 House Office Bldg. Annapolis 21401 ext. 3297	6615 Reisterstown Rd. Suite 301 Baltimore 21215 410-764-3614	42	Baltimore City	1
Del. Samuel I. Rosenberg	320 House Office Bldg. Annapolis 21401 ext. 3297	6615 Reisterstown Rd. Suite 301 Baltimore 21215 410-764-3614	42	Baltimore City	9

Legislator	Session address	District address	Legis. district	County/city	Years in legis.
Sen. John A. Pica, Jr.	402A Senate Office Bldg. Annapolis 21401 ext. 3145	402A Senate Office Bldg. Annapolis 21401 ext. 3145	43	Baltimore City	13
Del. Gerald J. Curran	321 House Office Bldg. Annapolis 21401 ext. 3308	Cromwell Center, Suite 200 809 Glencagles Court Towson 21204 410-821-2920	43	Baltimore City	25
Del. Ann Marie Doory	321 House Office Bldg. Annapolis 21401 ext. 3308	112 Taplow Rd. Baltimore 21212 410-323-0401	43	Baltimore City	5
Del. Henry R. Hergenroeder, Jr.	321 House Office Bldg. Annapolis 21401 ext. 3308	344 Homeland Southway Apt. 3-A Baltimore 21212 410-433-4093	43	Baltimore City	25
Sen. Julian L. Lapidés	116 Senate Office Bldg. Annapolis 21401 ext. 3686	807 Cathedral St. Baltimore 21201 410-752-4519	44	Baltimore City	29
Del. Curt Anderson	301 House Office Bldg. Annapolis 21401 ext. 3259	2225 St. Paul St. Baltimore 21218 410-467-4444	44	Baltimore City	9
Del. Kenneth C. Montague, Jr.	301 House Office Bldg. Annapolis 21401 ext. 3257	1532 Havenwood Rd. Northwood Shopping Ctr. Baltimore 21218 410-243-3904	44	Baltimore City	5
Del. Anne Scarlett Perkins	141 House Office Bldg. Annapolis 21401 ext. 3502	1532 Havenwood Rd. Northwood Shopping Ctr. Baltimore 21218 410-243-3904	44	Baltimore City	13
Sen. Nathan C. Irby, Jr.	214 Senate Office Bldg. Annapolis 21401 ext. 3165	2021 E. Biddle St. Baltimore 21213 410-675-3000	45	Baltimore City	9
Del. Clarence Davis	323 House Office Bldg. Annapolis 21401 ext. 3325	P.O. Box 33167 Baltimore 21218 410-366-0483	45	Baltimore City	9
Del. John Douglass	323 House Office Bldg. Annapolis 21401 ext. 3325	1535 East North Ave. Baltimore 21213 410-752-6653	45	Baltimore City	20
Del. Hattie N. Harrison	323 House Office Bldg. Annapolis 21401 ext. 3325	1054 N. Milton St. Baltimore 21213 410-342-4414	45	Baltimore City	18
Sen. American Joe Miedusiewski	311 Senate Office Bldg. Annapolis 21401 ext. 3598	421 South Highland Ave. Baltimore 21224 410-276-8225	46	Baltimore City	17
Del. Anthony M. DiPietro, Jr.	316 House Office Bldg. Annapolis 21401 ext. 3303	225 South Clinton St. Baltimore 21224 410-325-5400	46	Baltimore City	13
Del. Cornell N. Dypski	316 House Office Bldg. Annapolis 21401 ext. 3303	638 S. Decker Ave. Baltimore 21224 410-276-1974	46	Baltimore City	12
Del. Carolyn D. Krysiak	316 House Office Bldg. Annapolis 21401 ext. 3303	364 Cornwall St. Baltimore 21224 410-633-2927	46	Baltimore City	1

Legislator	Session address	District address	Legis. district	County/city	Years in legis.
Sen. George W. Della, Jr.	207 Senate Office Bldg. Annapolis 21401 ext. 3600	801 Light St. Baltimore 21230 410-244-8400	47	Baltimore City	9
Del. R. Charles Avara	429 House Office Bldg. Annapolis 21401 ext. 3547	3508 Coolidge Ave. Baltimore 21229 410-644-3057	47	Baltimore City	25
Del. Brian K. McHale	322 House Office Bldg. Annapolis 21401 ext. 3319	801 Light St., 2nd Floor Baltimore 21230 410-244-8400	47	Baltimore City	1
Del. Paul E. Weisengoff	322 House Office Bldg. Annapolis 21401 ext. 3319	1904 Griffis Ave. Baltimore 21230 410-644-6144	47	Baltimore City	25
Sen. Michael J. Collins	211 Senate Office Bldg. Annapolis 21401 ext. 3642	418 Eastern Blvd. Baltimore 21221 410-391-7800	6	Baltimore County	12
Del. Leslie D. Hutchinson	303 House Office Bldg. Annapolis 21401 ext. 3384	331 Lorraine Ave. Baltimore 21221 410-687-2037	6	Baltimore County	1
Del. E. Farrell Maddox	305 House Office Bldg. Annapolis 21401 ext. 3332	418 Eastern Blvd. Baltimore 21221 410-391-7800	6	Baltimore County	5
Del. Michael H. Weir	303 House Office Bldg. Annapolis 21401 ext. 3384	611 Weir Lane Baltimore 21221 410-686-4947	6	Baltimore County	17
Sen. Norman R. Stone, Jr.	216 Senate Office Bldg. Annapolis 21401 ext. 3587	6905 Dunmanway Dundalk 21222 410-288-5270	7	Baltimore County	28
Del. John S. Arnick	121 House Office Bldg. Annapolis 21401 ext. 3488	7918 Diehlwood Rd. Baltimore 21222 410-285-2209	7	Baltimore County	21
Del. Louis L. DePazzo	305 House Office Bldg. Annapolis 21401 ext. 3334	38 South Dundalk Ave. Dundalk 21222 410-288-9303	7	Baltimore County	13
Del. Connie C. Galiazzo	305 House Office Bldg. Annapolis 21401 ext. 3334	1951 Sunberry Rd. Baltimore 21222 410-285-0430	7	Baltimore County	1
Sen. Thomas L. Bromwell	215 Senate Office Bldg. Annapolis 21401 ext. 3620	7503 Belair Rd. Baltimore 21236 410-665-5470	8	Baltimore County	9
Del. Joe Bartenfelder	307 House Office Bldg. Annapolis 21401 ext. 3365	8410 Belair Rd. Baltimore 21236 410-529-2144	8	Baltimore County	8
Del. James F. Ports	307 House Office Bldg. Annapolis 21401 ext. 3365	4546 Fitch Ave. Baltimore 21236 410-665-5871	8	Baltimore County	1
Del. Alfred W. Redmer, Jr.	307 House Office Bldg. Annapolis 21401 ext. 3365	4101 Kahlston Rd. Baltimore 21236 410-256-9513	8	Baltimore County	1

Legislator	Session address	District address	Legis. district	County/city	Years in legis.
Sen. F. Vernon Boozer	410 Senate Office Bldg. Annapolis 21401 ext. 3706	614 Bosley Ave. Towson 21204 410-828-0669	9	Baltimore County	17
Del. John J. Bishop	308 House Office Bldg. Annapolis 21401 ext. 3359	7905 Oakdale Ave. Towson 21204 410-661-5408	9	Baltimore County	5
Del. Gerry L. Brewster	308 House Office Bldg. Annapolis 21401 ext. 3359	527 Allegheny Ave. Towson 21204 410-821-1991	9	Baltimore County	1
Del. Martha S. Klima	308 House Office Bldg. Annapolis 21401 ext. 3359	1403 Newport Pl. Lutherville 21093 410-337-2799	9	Baltimore County	9
Sen. Janice D. Piccinini	308 Senate Office Bldg. Annapolis 21401 ext. 3606	201 W. Padonia Rd. Timonium 21093 410-666-2000	10	Baltimore County	1
Del. Robert L. Ehrlich, Jr.	309 House Office Bldg. Annapolis 21401 ext. 3350	5 Elphin Ct., #102 Timonium 21093 410-252-4180	10	Baltimore County	5
Del. A. Wade Kach	309 House Office Bldg. Annapolis 21401 ext. 3350	214 Ashland Rd. Cockeysville 21031 410-527-1962	10	Baltimore County	17
Del. Ellen R. Sauerbrey	312 House Office Bldg. Annapolis 21401 ext. 3401	4122 Sweet Air Rd. Baldwin 21013 410-592-2200	10	Baltimore County	13
Sen. Paula C. Hollinger	206 Senate Office Bldg. Annapolis 21401 ext. 3131	206 Senate Office Bldg. Annapolis 21401 ext. 3131	11	Baltimore County	12
Del. Leon Albin	310 House Office Bldg. Annapolis 21401 ext. 3342	6512 Edenvale Rd. Baltimore 21209 410-486-1365	11	Baltimore County	5
Del. Theodore Levin	310 House Office Bldg. Annapolis 21401 ext. 3342	114 Slade Ave. Baltimore 21208 410-486-0462	11	Baltimore County	17
Del. Richard Rynd	310 House Office Bldg. Annapolis 21401 ext. 3342	8570 Leisure Hill Dr. Baltimore 21208 410-363-0690	11	Baltimore County	12
Sen. Nancy L. Murphy	205 Senate Office Bldg. Annapolis 21401 ext. 3653	1330 Sulphur Spring Rd. 2nd Floor Baltimore 21227 410-242-5699	12	Baltimore County	10
Del. Thomas E. Dewberry	304 House Office Bldg. Annapolis 21401 ext. 3378	1917 Tadcaster Rd. Catonsville 21228 410-747-0407	12	Baltimore County	3
Del. Kenneth H. Masters	304 House Office Bldg. Annapolis 21401 ext. 3378	304 House Office Bldg. Annapolis 21401 ext. 3378	12	Baltimore County	13
Del. Louis P. Morsberger	304 House Office Bldg. Annapolis 21401 ext. 3378	612 Hilton Ave. Catonsville 21228 410-747-0407	12	Baltimore County	17

Legislator	Session address	District address	Legis. district	County/city	Years in legis.
Sen. Larry E. Haines	403 Senate Office Bldg. Annapolis 21401 ext. 3683	532 Baltimore Blvd. Westminster 21157 410-876-4530	5	Baltimore, Carroll Counties	1
Del. Richard N. Dixon	306 House Office Bldg. Annapolis 21401 ext. 3371	1224 Western Chapel Rd. New Windsor 21776 410-848-6945	5	Carroll County	9
Del. Lawrence A. LaMotte	209 House Office Bldg. Annapolis 21401 ext. 3109	2702 Melrose Ave. Woodstock 21163 410-461-5548	5	Baltimore, Carroll Counties	9
Del. Richard C. Matthews	306 House Office Bldg. Annapolis 21401 ext. 3371	1309 Taylor St. Hampstead 21074 410-239-7600	5	Carroll County	25
Sen. Walter M. Baker	301 Senate Office Bldg. Annapolis 21401 ext. 3639	153 East Main St. Elkton 21921 410-398-0980	36	Caroline, Cecil, Kent, Queen Anne's, Talbot Counties	13
Del. C. Roland Franks	405 House Office Bldg. Annapolis 21401 ext. 3410	154 Winchester Creek Rd. Grasonville 21638 410-827-7600	36	Caroline, Cecil, Kent, Queen Anne's, Talbot Counties	1
Del. Ronald A. Guns	161 House Office Bldg. Annapolis 21401 ext. 3442	107 Railroad Ave. Elkton 21921 410-392-4422	36	Caroline, Cecil, Kent, Queen Anne's, Talbot Counties	9
Del. R. Clayton Mitchell, Jr.	H100 State House Annapolis 21401 ext. 3800	H100 State House Annapolis 21401 ext. 3800	36	Caroline, Cecil, Kent, Queen Anne's, Talbot Counties	21
Sen. Frederick C. Malkus, Jr.	PW Senate Office Bldg. Annapolis 21401 ext. 3590	500 Spring Street P.O. Box 316 Cambridge 21613 410-276-8225	37	Caroline, Dorchester, Talbot, Wicomico Counties	45
Del. Samuel Q. Johnson III	415 House Office Bldg. Annapolis 21401 ext. 3427	P.O. Box 200 Hebron 21830 410-546-2400	37	Caroline, Dorchester, Talbot, Wicomico Counties	9
Del. Robert Thornton, Jr.	404 House Office Bldg. Annapolis 21401 ext. 3343	118 Market St. Denton 21629 410-479-2594	37	Caroline, Dorchester, Talbot, Wicomico Counties	1
Del. Kenneth D. Schisler	414 House Office Bldg. Annapolis 21401 ext. 3429	Stewart Bldg., Ste. 223 Easton 21601 410-822-8682	37	Caroline, Dorchester, Talbot, Wicomico Counties	1
Sen. Charles H. Smelser	100 Senate Office Bldg. Annapolis 21401 ext. 3704	100 Senate Office Bldg. Annapolis 21401 ext. 3704	4	Carroll, Frederick, Howard Counties	36
Del. Donald B. Elliott	306 House Office Bldg. Annapolis 21401 ext. 3371	204 Lambert Ave. Box 370 New Windsor 21776 410-848-5373	4	Carroll, Howard Counties	5
Del. Thomas H. Hattery	209 House Office Bldg. Annapolis 21401 ext. 3107	P.O. Box 88 Mount Airy 21771 301-694-0123	4	Frederick County	9
Del. George H. Littrell, Jr.	209 House Office Bldg. Annapolis 21401 ext. 3107	5209 Reel's Mill Rd. Frederick 21701 301-662-4367	4	Frederick County	9

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Sen. William H. Amoss	401 Senate Office Bldg. Annapolis 21401 ext. 3603	2303 Bel Air Rd. P.O. Box 496 Fallston 21047 410-879-7272	35	Cecil, Harford Counties	16
Del. Donald C. Fry	326 House Office Bldg. Annapolis 21401 ext. 3289	1716 Edwin Dr. Bel Air 21014 410-836-6747	35	Harford County	1
Del. James M. Harkins	326 House Office Bldg. Annapolis 21401 ext. 3289	1201 Old Pylesville Rd. Whiteford 21160 410-336-6636	35	Cecil County	1
Del. Ethel Ann Murray	403 House Office Bldg. Annapolis 21401 ext. 3444	553 Jackson Hall School Elkton 21921 410-398-2040	35	Harford County	9
Sen. James C. Simpson	316 Senate Office Bldg. Annapolis 21401 ext. 3616	P.O. Box 188 Waldorf 20604 301-645-2235	28	Charles, St. Mary's Counties	17
Del. Stephen J. Braun	216 House Office Bldg. Annapolis 21401 ext. 3247	P.O. Box 2037 Waldorf 20604 301-932-5812	28	Charles County	1
Del. Michael J. Sprague	216 House Office Bldg. Annapolis 21401 ext. 3247	P.O. Box 37 Bryans Road 20616 301-375-7995	28	Charles County	17
Del. John F. Wood, Jr.	216 House Office Bldg. Annapolis 21401 ext. 3247	6230 Leonardtown Rd. Mechanicsville 20659 301-884-3233	28	Charles, St. Mary's Counties	5
Sen. John W. Derr	408 Senate Office Bldg. Annapolis 21401 ext. 3575	13 West Second St. Frederick 21701 301-695-5733	3	Frederick, Washington Counties	8
Del. James E. McClellan	324 House Office Bldg. Annapolis 21401 ext. 3240	215 Rockwell Terrace Frederick 21701 301-662-3804	3	Frederick, Washington Counties	13
Del. Bruce Poole	426 House Office Bldg. Annapolis 21401 ext. 3464	24 Jonathan St., Suite 207 Hagerstown 21740 301-739-6409	3	Washington County	5
Del. J. Anita Stup	324 House Office Bldg. Annapolis 21401 ext. 3240	587 Pumphouse Rd. Frederick 21701 301-663-5943	3	Frederick, Washington Counties	1
Sen. Habern Freeman	202 Senate Office Bldg. Annapolis 21401 ext. 3158	730 Town Center Dr. Joppa 21085 410-638-1714	34	Harford County	1
Del. Rose Mary Bonsack	326 House Office Bldg. Annapolis 21401 ext. 3289	205 Hemlock Lane Aberdeen 21001 410-575-6438	34	Harford County	1
Del. David R. Craig	326 House Office Bldg. Annapolis 21401 ext. 3289	453 Congress Ave. Havre de Grace 21078 410-939-9398	34	Harford County	1
Del. Mary Louise Preis	326 House Office Bldg. Annapolis 21401 ext. 3289	35 W. Gordon St. Bel Air 21014 410-838-5890	34	Harford County	1

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Sen. Thomas M. Yeager	309 Senate Office Bldg. Annapolis 21401 ext. 3572	413 Main St. Laurel 20707 301-498-3400	13	Howard, Prince George's Counties	8
Del. Martin G. Madden	219 House Office Bldg. Annapolis 21401 ext. 3205	11524 Crows Nest Rd. Clarksville 21029 301-596-9788	13	Howard, Prince George's Counties	1
Del. John S. Morgan	219 House Office Bldg. Annapolis 21401 ext. 3205	9070 Stebbing Way, Apt. A Laurel 20723 301-776-0806	13	Howard, Prince George's Counties	1
Del. Virginia M. Thomas	219 House Office Bldg. Annapolis 21401 ext. 3205	6153 Forty Winks Way Columbia 21045 410-730-0485	13	Howard County	9
Sen. Christopher J. McCabe	404 Senate Office Bldg. Annapolis 21401 ext. 3671	12400 Clarksville Pike Clarksville 21029 410-988-9818	14	Howard, Montgomery Counties	1
Del. Joel Chasnoff	121 House Office Bldg. Annapolis 21401 ext. 3052	17904 Georgia Ave. Olney Bldg., Suite 210 Olney 20832 301-924-4200	14	Montgomery County	17
Del. Robert L. Flanagan	226 House Office Bldg. Annapolis 21401 ext. 3200	12400 Clarksville Pike Clarksville 21029 410-988-9818	14	Howard County	5
Del. Robert H. Kittleman	312 House Office Bldg. Annapolis 21401 ext. 3401	12400 Clarksville Pike Clarksville 21029 410-988-9818	14	Howard County	9
Sen. Laurence Levitan	100 Senate Office Bldg. Annapolis 21401 ext. 3169	100 Senate Office Bldg. Annapolis 21401 ext. 3169	15	Montgomery County	20
Del. Gene W. Counihan	100 House Office Bldg. Annapolis 21401 ext. 3521	9901 Dellcastle Rd. Gaithersburg 20879 301-977-5045	15	Montgomery County	9
Del. Richard LaVay	220 House Office Bldg. Annapolis 21401 ext. 3090	14000 Crossland Lane Gaithersburg 20878 301-840-0806	15	Montgomery County	1
Del. Jean Roesser	225 House Office Bldg. Annapolis 21401 ext. 3037	10830 Fox Hunt Lane Potomac 20854 301-299-9046	15	Montgomery County	5
Sen. Howard A. Denis	402B Senate Office Bldg. Annapolis 21401 ext. 3124	402B Senate Office Bldg. Annapolis 21401 ext. 3124	16	Montgomery County	14
Del. Brian E. Frosh	220 House Office Bldg. Annapolis 21401 ext. 3001	7315 Wisconsin Ave. Suite 800 West Bethesda 20814 301-652-2888	16	Montgomery County	5
Del. Gilbert J. Genn	224 House Office Bldg. Annapolis 21401 ext. 3011	11300 Rockville Pike 1 Central Plaza, Suite 1204 North Bethesda 20852 301-881-7700	16	Montgomery County	5
Del. Nancy K. Kopp	313 House Office Bldg. Annapolis 21401 ext. 3391	313 House Office Bldg. Annapolis 21401 ext. 3391	16	Mongtomery County	17

Legislator	Session address	District address	Legis. district	County/city	Years in legis.
Sen. Mary Boergers	208 Senate Office Bldg. Annapolis 21401 ext. 3134	4417 Puller Dr. Kensington 20895 301-564-0508	17	Montgomery County	10
Del. Kumar P. Barve	224 House Office Bldg. Annapolis 21401 ext. 3046	11 Pontiac Way Gaithersburg 20878 301-869-1488	17	Montgomery County	1
Del. Jennie M. Forehand	223 House Office Bldg. Annapolis 21401 ext. 3028	712 Smallwood Road Rockville 20850 301-762-4772	17	Montgomery County	13
Del. Michael R. Gordon	222 House Office Bldg. Annapolis 21401 ext. 3001	416 Hungerford Dr. Rockville 20850 301-294-2100	17	Montgomery County	9
Sen. Patricia R. Sher	PW Senate Office Bldg. Annapolis 21401 ext. 3137	1916 Rookwood Rd. Silver Spring 20910 301-589-7188	18	Montgomery County	13
Del. Patricia Billings	226 House Office Bldg. Annapolis 21401 ext. 3200	3940 Rickover Rd. Silver Spring 20910 301-946-5916	18	Montgomery County	3
Del. John A. Hurson	224 House Office Bldg. Annapolis 21401 ext. 3011	14 Kentbury Way Bethesda 20814 301-656-6823	18	Montgomery County	1
Del. Christopher Van Hollen, Jr.	223 House Office Bldg. Annapolis 21401 ext. 3045	3514 Farragut Ave. Kensington 20895 301-942-8581	18	Montgomery County	1
Sen. Idamae Garrott	304 Senate Office Bldg. Annapolis 21401 ext. 3151	304 Senate Office Bldg. Annapolis 2140 ext. 3151	19	Montgomery County	11
Del. Henry B. Heller	222 House Office Bldg. Annapolis 21401 ext. 3001	12706 Turkey Branch Pkwy. Rockville 20853 301-949-4265	19	Montgomery County	5
Del. Carol S. Petzold	225 House Office Bldg. Annapolis 21401 ext. 3037	14113 Chadwick Lane Rockville 20853 301-871-7413	19	Montgomery County	5
Del. Leonard H. Teitelbaum	221 House Office Bldg. Annapolis 21401 ext. 3019	11805 Auth Lane Silver Spring 20902 301-921-8282	19	Montgomery County	5
Sen. Ida G. Ruben	204 Senate Office Bldg. Annapolis 21401 ext. 3634	11 Schindler Court Silver Spring 20903 301-439-2332	20	Montgomery County	16
Del. Dana Lee Dembrow	226 House Office Bldg. Annapolis 21401 ext. 3200	11215 Oakleaf Dr. #908 Silver Spring 20901 301-593-5359	20	Montgomery County	5
Del. Peter Franchot	220 House Office Bldg. Annapolis 21401 ext. 3045	7111 Sycamore Ave. Takoma Park 20912 301-270-8417	20	Montgomery County	5
Del. Sheila Hixson	221 House Office Bldg. Annapolis 21401 ext. 3019	1008 Broadmore Circle Silver Spring 20904 301-384-4739	20	Montgomery County	15

Legislator	Session address	District address	Legis. district	County/city	Years in legis.
Sen. Arthur Dorman	303 Senate Office Bldg. Annapolis 21401 ext. 3141	303 Senate Office Bldg. Annapolis 21401 ext. 3141	21	Prince George's County	26
Del. Timothy F. Maloney	424 House Office Bldg. Annapolis 21401 ext. 3315	424 House Office Bldg. Annapolis 21401 ext. 3315	21	Prince George's County	13
Del. Pauline H. Menes	210 House Office Bldg. Annapolis 21401 ext. 3114	3517 Marlborough Way College Park 20740 301-935-6270	21	Prince George's County	25
Del. James C. Rosapepe	210 House Office Bldg. Annapolis 21401 ext. 3114	210 House Office Bldg. Annapolis 21401 ext. 3114	21	Prince George's County	5
Sen. Thomas P. O'Reilly	PW Sen. Off. Bldg. Annapolis 21401 ext. 3155	7219 Hanover Pkwy. Suites C & D Greenbelt 20770 301-345-6900	22	Prince George's County	17
Del. Anne Healy	207 House Office Bldg. Annapolis 21401 ext. 3058	3920 Madison St. Hyattsville 20781 301-779-4515	22	Prince George's County	1
Del. Richard A. Palumbo	207 House Office Bldg. Annapolis 21401 ext. 3058	4004 St. Barnabas Rd. Suitland 20746 301-423-8300	22	Prince George's County	13
Del. Paul G. Pinsky	207 House Office Bldg. Annapolis 21401 ext. 3058	6205 Inwood St. Cheverly 20785 301-772-1287	22	Prince George's County	5
Sen. Leo E. Green	212 Senate Office Bldg. Annapolis 21401 ext. 3631	3123 Belair Dr. Bowie 20715 301-464-8777	23	Prince George's County	13
Del. Mary A. Conroy	208 House Office Bldg. Annapolis 21401 ext. 3098	208 House Office Bldg. Annapolis 21401 ext. 3098	23	Prince George's County	5
Del. Joan Breslin Pitkin	208 House Office Bldg. Annapolis 21401 ext. 3098	12005 Long Ridge Lane Bowie 20715 301-262-0538	23	Prince George's County	13
Del. Charles J. Ryan	131 House Office Bldg. Annapolis 21401 ext. 3407	131 House Office Bldg. Annapolis 21401 ext. 3407	23	Prince George's County	13
Sen. Decatur W. Trotter	313 Senate Office Bldg. Annapolis 21401 ext. 3148	313 Senate Office Bldg. Annapolis 21401 ext. 3148	24	Prince George's County	12
Del. Joanne C. Benson	204 House Office Bldg. Annapolis 21401 ext. 3065	5611 Landover Rd. Mitchell Bldg. 2nd Fl. Hyattsville 20784 410-272-7502	24	Prince George's County	1
Del. Nathaniel Exum	204 House Office Bldg. Annapolis 21401 ext. 3065	5611 Landover Rd. Hyattsville 20784 301-277-7501	24	Prince George's County	17
Del. Sylvania W. Woods, Jr.	201 House Office Bldg. Annapolis 21401 ext. 3074	5611 Landover Rd. Hyattsville 20784 301-277-7503	24	Prince George's County	13

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Sen. Albert R. Wynn	302 Senate Office Bldg. Annapolis 21401 ext. 3127	8700 Central Ave. Suite 306 Landover 20785 301-350-5055	25	Prince George's County	8
Del. Michael Arrington	203 House Office Bldg. Annapolis 21401 ext. 3076	642 Mt. Lubentia Ct. E Largo 20772 301-336-0058	25	Prince George's County	1
Del. Ulysses Currie	203 House Office Bldg. Annapolis 21401 ext. 3076	7315 Calder Dr. Capitol Heights 20743 301-350-3345	25	Prince George's County	5
Del. Beatrice D. Tignor	203 House Office Bldg. Annapolis 21401 ext. 3076	11411 Lake Arbor Way #203 Mitchellville 20721 301-249-4489	25	Prince George's County	1
Sen. Gloria Lawlah	307 Senate Office Bldg. Annapolis 21401 ext. 3092	3801 24th Ave. Hillcrest Heights 20748 301-894-3082	26	Prince George's County	5
Del. Rosa Lee Blumenthal	205 House Office Bldg. Annapolis 21401 ext. 3012	4400 Stamp Rd., Suite 212 Temple Hills 20748 301-423-4130	26	Prince George's County	5
Del. Christine M. Jones	205 House Office Bldg. Annapolis 21401 ext. 3012	3518 Everest Dr. Hillcrest Heights 20748 301-505-4052	26	Prince George's County	9
Del. David Valderrama	205 House Office Bldg. Annapolis 21401 ext. 3012	9708 Potomac Dr. Ft. Washington 20744 301-839-7247	26	Prince George's County	1
Sen. Thomas V. Mike Miller, Jr.	H107 State House Annapolis 21401 ext. 3700	H107 State House Annapolis 21401 ext. 3700	27	Prince George's County	17
Del. Gary R. Alexander	151 House Office Bldg. Annapolis 21401 ext. 3519	11414 Livingston Rd. Ft. Wash. Prof. Park Ft. Washington 20744 301-292-3300	27	Prince George's County	5
Del. James E. Proctor, Jr.	206 House Office Bldg. Annapolis 21401 ext. 3083	11204 Cedarville Rd. Brandywine 20613 301-888-9353	27	Prince George's County	1
Del. Joseph F. Vallario, Jr.	206 House Office Bldg. Annapolis 21401 ext. 3083	5210 Auth Rd., 6th Flr. Suitland 20746 301-423-8100	27	Prince George's County	16
Sen. Lewis R. Riley	409 Senate Office Bldg. Annapolis 21401 ext. 3645	Box 130 Parsonsburg 21849 410-742-3999	38	Somerset, Wicomico, Worcester Counties	12
Del. Bennett Bozman	413 House Office Bldg. Annapolis 21401 ext. 3431	103 Cedar Ave. Berlin 21811 410-641-2221	38	Somerset, Wicomico, Worcester Counties	1
Del. Norman H. Conway	416 House Office Bldg. Annapolis 21401 ext. 3425	1312 Whittier Dr. Salisbury 21801 410-543-9060	38	Somerset, Wicomico, Worcester Counties	5
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Diagnosis and management of asymptomatic primary hyperparathyroidism: Summary of the National Institutes of Health (NIH) consensus statement

Multiphasic screening tests that detect hypercalcemia are identifying 100,000 new cases of hyperparathyroidism (HPT) in the U.S. each year, including many patients who have no symptoms of the disease. Women are affected twice as often as men, and the incidence of HPT increases with age.

Parathyroidectomy is a highly successful treatment for this disorder when performed by experienced surgeons. Some patients with asymptomatic primary hyperparathyroidism may have a prolonged benign course, and these patients may be managed without surgery. If patients do not have surgery, they must be monitored to detect progression of the disease. For these patients, the principal issue is how this can best be accomplished, balancing the need to identify skeletal, renal, or other complications that are indications for surgery against the burdens and expense of long-term monitoring.

To evaluate these issues, the National Institute of Diabetes and Digestive and Kidney Diseases and the Office of Medical Applications of Research of the National Institutes of Health held a Consensus Development Con-

ference on the Diagnosis and Management of Asymptomatic Primary Hyperparathyroidism October 29-31, 1990.

According to the panel, the diagnosis of HPT is based on two findings: persistent hypercalcemia along with elevated serum parathyroid hormone (PTH). Immunoassays for intact PTH using double antibody methods have simplified diagnosis.

Although all primary HPT patients should be considered candidates for surgery, the panel agreed that there may be a subgroup of patients with primary HPT that can be safely followed. Decisions regarding surgical or medical management must remain founded on clinical judgment on a case-by-case basis. The only acceptable treatment for these patients other than surgery is conscientious, long-term medical surveillance.

To qualify for nonsurgical management, a patient must have a serum calcium that is only mildly elevated, no previous episodes of life-threatening hypercalcemia, and normal renal and bone status. The panel recommended surgery for asymptomatic patients with any of the following indications: markedly elevated serum calcium; history of an

Diagnosis and management of asymptomatic primary hyperparathyroidism: A commentary

What does one do when a laboratory result returns revealing hypercalcemia in a patient not suspected to be ill? The answer is to confirm hypercalcemia with another serum calcium measurement, review the history and physical examination to sort out the various disorders that exist in the differential diagnosis of hypercalcemia, and then obtain a parathyroid hormone immunoassay (iPTH). The possibility is high that you have a patient with primary hyperparathyroidism (1° HPT). What to do from this point is the issue the National Institutes of Health (NIH) conference addressed.

Perspective

For the past quarter of a century, there has been a debate in the medical literature concerning what is the more appropriate management for just such a patient — medical surveillance or parathyroid surgery. It is important to recall that the descriptions of 1° HPT made in the early part of this century emphasized multisystem organ involvement.¹ Osteitis fibrosa cystica and renal stones were the most notable complications of the disease. Other important symptoms involved the gastrointestinal (peptic ulcer and pancreatitis, nonspecific abdominal pain), neuromuscular (lower extremity myopathy), and central nervous (alterations in mental status, personality changes) systems. The best chance for a cure that restored the serum calcium to normal was, and still

is, to have an experienced parathyroid surgeon perform neck exploration and remove abnormal parathyroid tissue.

In recent decades, the clinical presentation of 1° HPT has changed. The diagnosis is made earlier in the clinical course, partly because of increased physician awareness of the disease and, more frequently, because of blood screening tests that detect hypercalcemia. Many of these patients are considered asymptomatic.

The incidence of 1° HPT increases with age. Over 60 years of age, 1° HPT occurs twice as frequently in women (2/1000) as compared with men.² This group now represents the majority of 1° HPT patients and is usually seen by the primary physician.

Over the years, reports have suggested that a segment of asymptomatic 1° HPT patients may have a stable clinical course and that it is safe to medically follow them for many years.³⁻⁶ For example, 147 asymptomatic patients from the Mayo Clinic series were selected to be medically followed because of mild biochemical hyperparathyroidism. Serum calcium was < 11.0 mg/dl (8.9-10.1), and there was no objective roentgenographic evidence of bone or renal disease. During ten years of medical follow-up, 14 percent of the study population showed no progression of their disease. This is reassuring for those individuals who choose not to have parathyroid surgery or for those elderly patients who have serious concomitant illnesses that increase the risk from surgery.

Commentary

episode of life-threatening hypercalcemia; reduced creatinine clearance; presence of kidney stone(s) detected by abdominal radiograph; markedly elevated 24-hour urinary calcium excretion; or substantially reduced bone mass.

Surgery is also indicated if consistent follow-up seems unlikely; if coexistent illness complicates management; if the patient requests surgery or is younger than 50 years old, since the effects of decades of HPT are unknown and long-term compliance may be inadequate and/or particularly burdensome for younger patients.

Physicians and patients who forgo surgery must commit to long-term, conscientious monitoring for early recognition of worsening hypercalcemia, bone deterioration, renal impairment, the appearance or growth of renal stones, or the onset of typical parathyroid symptoms. Any of these developments may warrant surgery.

The patient should be seen at least semiannually until the lack of progression of the disease has been established. Once stability of these parameters is established in one to three years, evaluation can occur less frequently. Patients should drink lots of water, get plenty of exercise, and avoid loop or thiazide diuretics, as well as diets with restricted or excess calcium.

The panel evaluated the extensive experience acquired with imaging methods for localization of parathyroids and

found that preoperative localization in patients without prior neck operation is rarely indicated and not proven to be cost-effective.

The panel called for basic research into the causes of hyperparathyroidism, its molecular and cellular pathophysiology, and for the development of pharmacologic treatment. Additional studies should define the neuromuscular, psychological, cardiovascular and gastrointestinal effects of primary HPT, as well as its effect on bone strength and susceptibility to fracture. They further suggested a preliminary clinical trial in postmenopausal women randomized for estrogen therapy and surgery versus estrogen alone to provide data on bone mass and bone turnover without the confounding effects of estrogen deficiency. Such a trial would focus on the population with the highest incidence of HPT. Ultimately, the panel sees a need for a randomized, multicenter clinical trial to compare operative versus nonoperative management of asymptomatic hyperparathyroidism.

Single copies of the complete *NIH Consensus Statement on diagnosis and management of asymptomatic primary hyperparathyroidism* may be ordered from the Office of Medical Applications of Research, National Institutes of Health, Building 1, Room 260, 9000 Rockville Pike, Bethesda, MD 20892, (301-496-1143).

Despite such reports, others still recommend parathyroid surgery for asymptomatic 1° HPT patients. For example, about 20 percent of the original number from the Mayo Clinic series required neck surgery. In addition, there were some patients in this study who did not undergo surgery but who experienced progression of their disease. It is further recommended by some that the operation be performed as soon as possible to avoid the potential for increased morbidity/mortality from silent hypertension, osteoporotic bone and renal disease, and psychiatric illness.^{7,8} Organ dysfunction discovered early is reversible or can be stabilized following successful parathyroid surgery.

The debate has continued because there have not been any randomized prospective studies concerning health outcome, quality of life, and economic considerations between asymptomatic 1° HPT patients who have not had surgery and those patients who have had parathyroid surgery. Because of this quandary, the NIH sponsored a public meeting in the fall of 1990 to discuss the diagnosis and management of asymptomatic 1° HPT. Twenty-one papers were presented by investigators who outlined their experience with patients who had 1° HPT. These experts included internists, endocrinologists, surgeons, radiologists, and epidemiologists. The presentations from the individual speakers are to be published in *Bone and Mineral*. After listening to these

presentations and subsequent discussions with the audience, a panel of 14 experts (also representing various specialties) arrived at a consensus statement designed to act as a set of guidelines for physicians. This summary appears above, but the entire report appears in the April 1, 1991 issue of the *Annals of Internal Medicine*. A copy of the full report can also be obtained from the address noted at the end of the summary.

The consensus statement attempts to give answers to the following six questions: (1) What is the most accurate, cost-effective method of diagnosing hyperparathyroidism? (2) Are there patients with asymptomatic hyperparathyroidism who can safely be followed? Should they be? (3) If not operated on, how should asymptomatic patients be monitored and managed? (4) What are the indications for surgery in patients with asymptomatic hyperparathyroidism? (5) What is the role of gland localization technology in the management of patients with hyperparathyroidism? (6) What research should be done to classify issues in the diagnosis and management of hyperparathyroidism?

It is beyond the scope of this discussion to review the answers given to all six questions. However, some points discussed at the consensus conference and incorporated into the complete consensus statement deserve comment and amplification.

Definition of asymptomatic 1° HPT

The definition of asymptomatic 1° HPT was a point of controversy at the consensus conference. The summary statement did not call attention to this debate. The complete consensus statement defined asymptomatic 1° HPT as being without symptoms or signs commonly attributable to the disease. The definition excluded "one or several vague symptoms that cannot be definitely attributed to 1° HPT and that may be nonspecific or that may arise from a co-existing condition."⁹ The consensus statement included hypertension as an example of a "vague symptom." Hypertension has a higher frequency in the older population and, therefore, its occurrence with primary 1° HPT may be a coincidence and not a complication of 1° HPT.

Others at the conference strongly disagreed with this distinction.^{10,11} They asserted that hypertension, as well as psychiatric symptoms and fatigue, is an important manifestation of 1° HPT. They also presented evidence that a thorough history can detect subtle symptoms so that true asymptomatic 1° HPT is unusual. This interpretation is also supported by reports of so-called asymptomatic patients who, after successful parathyroid surgery, noted relief from previously unrecognized symptoms.

Diagnosis of 1° HPT

Total serum calcium (corrected for hypoalbuminemia) is preferred over ionized serum measurements. All agreed on the value of the new immunometric or immunoradiometric assay (IRMA) double antibody immunoreactive parathyroid hormone (IPTH) that measures intact 1-84 parathyroid hormone (PTH). The assay result is elevated in the majority of patients with 1° HPT (80-90 percent) and in the upper normal range in the remainder of patients. The finding of a low normal or suppressed IPTH rules out 1° HPT; it is found in nonparathyroid causes of hypercalcemia such as patients with malignant hypercalcemia. This is important in the differential diagnosis of hypercalcemia. The IPTH by radioimmunoassay (RIA) methods does not always distinguish patients with malignant hypercalcemia from those with 1° HPT. This type of assay is not as sensitive as the double antibody immunoassay and it measures parathyroid hormone fragments (i.e., carboxyl terminal assays) that accumulate in renal failure. Deviations in serum electrolytes such as low serum PO₄, HCO₃, and elevated Cl, although consistent with 1° HPT, are not diagnostic.

When parathyroid surgery should be considered

The protocol recommended by the panel for medical surveillance requires a cooperative patient. The time and cost for the patient has to be compared to the expense related to parathyroid surgery. The consensus statement agreed that asymptomatic patients are definite candidates for surgery if

serum calcium determinations are greater than 12 mg/dl; the 11.4-12.0 mg/dl range was designated as a gray zone. Other criteria to use when considering parathyroid surgery include creatinine clearance reduced by 30 percent compared with age-matched controls (increasing serum creatinine levels from baseline to within or above the normal range may reflect silent renal damage), 24-hour urine calcium < 400 mg (while on a ~400 mg calcium diet), and low bone-density measurements greater than two standard deviations below appropriate age-, sex-, and race-matched controls. There is evidence that excess parathyroid hormone resorbs more cortical than trabecular bone. This leaves uncertainty as to which bone site should be evaluated. For example, the wrist or hip has more compact relative to cancellous bone compared with the vertebral spine which has more cancellous bone.¹² The advantages and disadvantages of noninvasive techniques to measure such bone loss were discussed. Dual energy x-ray absorptiometry (DEXA) is the most promising technique in terms of precision. Patients under 50 years of age should also be considered for surgery because the long-term natural history of the disease has not been clearly defined.

Noninvasive parathyroid localization studies

Thallium-technetium scintigraphy, ultrasonography, computed tomography, and magnetic resonance studies are not helpful in 1° HPT patients prior to neck exploration. These procedures are too often negative in patients who have 1° HPT. There is also a significant false-positive rate, and such a result might lure the inexperienced into believing parathyroid surgery would be appropriate, easier, and faster. These tests should not be used to establish a diagnosis of 1° HPT. Localization is best accomplished at the time of neck exploration by an experienced surgeon in parathyroid surgery.

Medical treatment of asymptomatic 1° HPT

Agents were discussed that could affect parathyroid hormone secretion or action on bone. Although the number of studies are few, the only promising oral therapy was the use of estrogens in postmenopausal patients; this therapy antagonizes parathyroid hormone action on bone. Oral diphosphonates have not been shown to be effective in correcting the hypercalcemia of 1° HPT. In general, medical therapy focuses on keeping 1° HPT patients hydrated and avoiding factors that can aggravate hypercalcemia, such as thiazide diuretics and immobilization.

Conclusion

The consensus panel came to a definition for asymptomatic 1° HPT, but it is not universally accepted. Future prospective investigations for this condition will need to keep this definition in mind however when comparing parathyroid surgery with medical follow-up. The individual physician is

Commentary

less served by this definition. The statement from the NIH conference does not yet provide a definitive answer to the question of how one is to manage asymptomatic hyperparathyroidism. In the interim, physicians must listen to each patient and consider any symptoms and treatment selection on the basis of their impact on the quality of life. Keep in mind that there may be risks in medical follow-up, and that parathyroid surgery, despite its risks, is the only cure.

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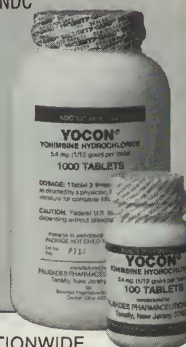
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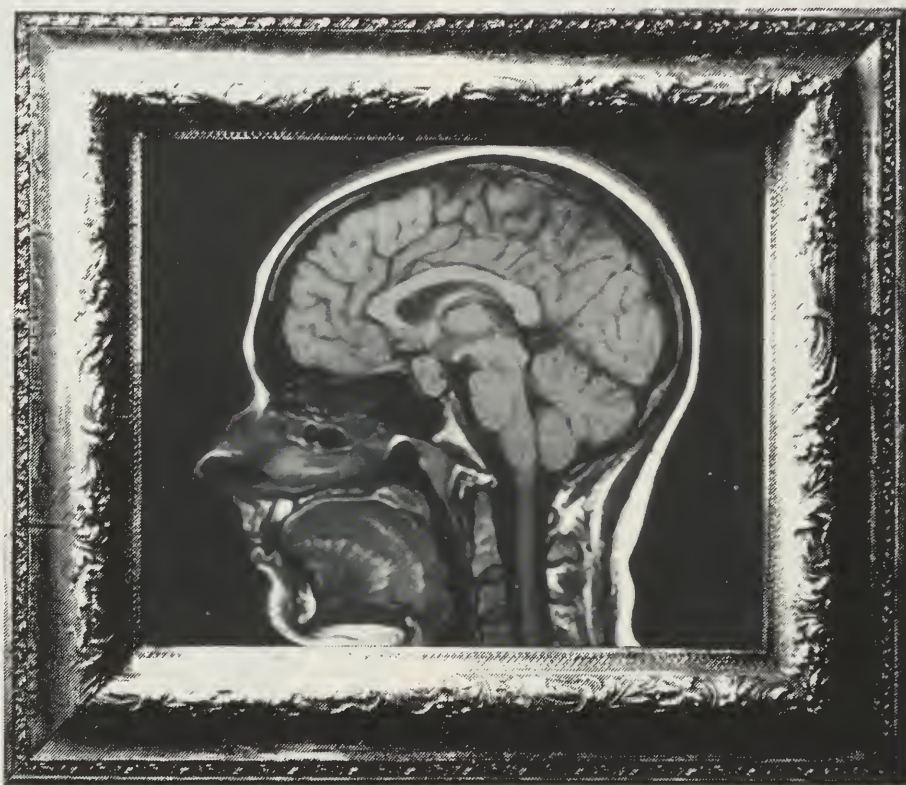


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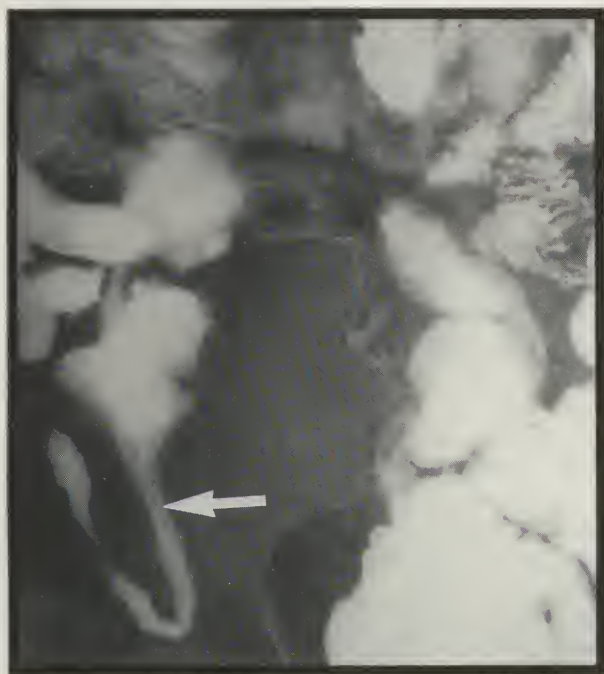


Figure 1.



Figure 2.

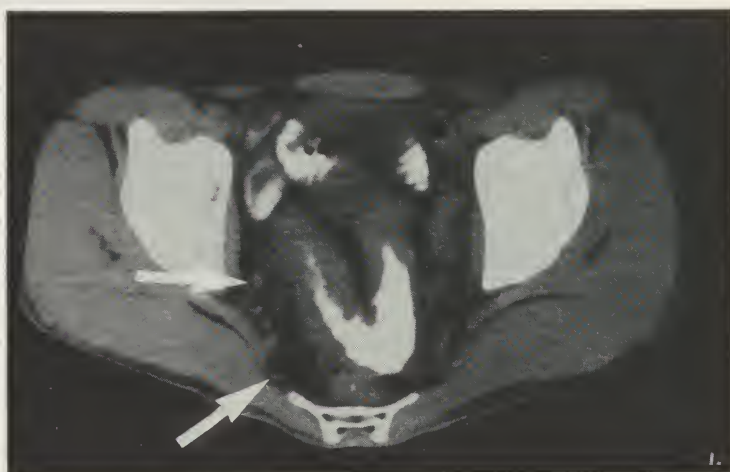


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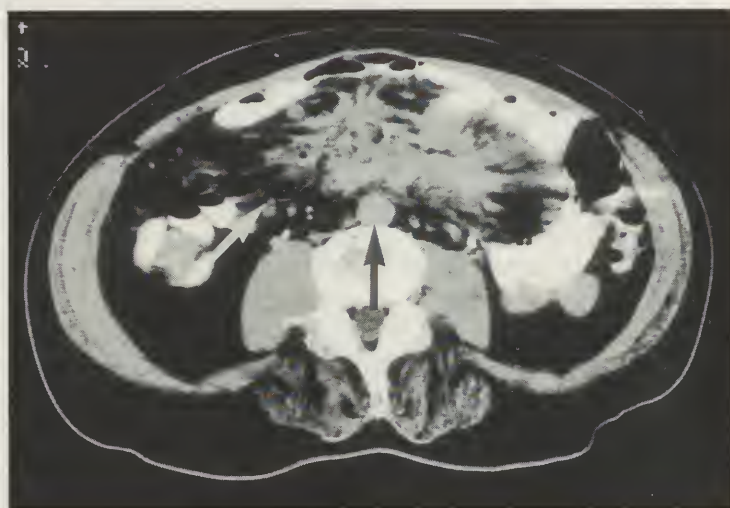


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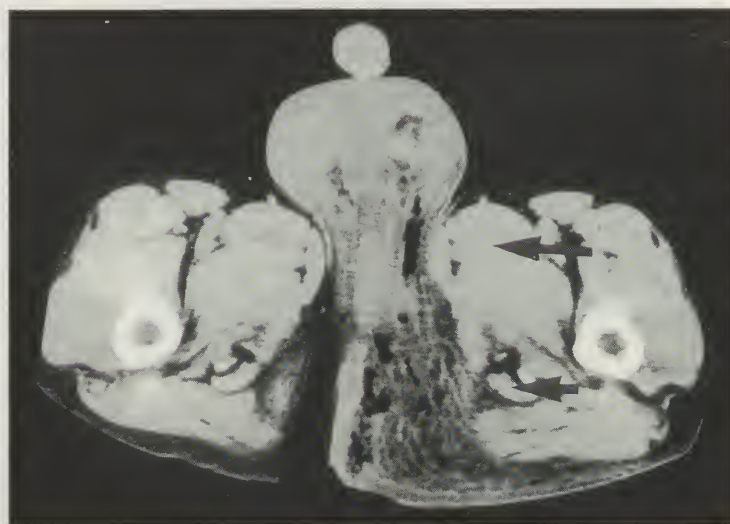


Figure 5.

Imaging Case of the Month

Crohn's disease involving the terminal ileum

Figure 1. Severely affected terminal ileum with luminal narrowing and an adjacent mesenteric mass separating loops of small bowel.

Figure 2. Compression radiograph of the terminal ileum demonstrates a narrowed lumen with cobblestoning produced by intersecting longitudinal and transverse ulcerations.

Figure 3. CT delineates the marked thickening of a pelvic loop of small bowel in this patient.

Figure 4. One of the extra intestinal manifestations of Crohn's disease is mesenteric abscesses, well demonstrated on this CT scan.

Figure 5. CT scan in a patient with Crohn's disease, demonstrating a perirectal abscess extending anteriorly into the scrotum.

Clinical features and pathology

Crohn's disease is an idiopathic chronic inflammatory disease of the gastrointestinal tract. It is a transmural disease with segmental involvement of bowel. The disease follows a protracted course and is frequently complicated by formation of fistulas and abscesses.

Patients usually present between 15 and 30 years of age with complaints of abdominal pain and diarrhea. Other features include fever, weight loss, and anemia. Active gastrointestinal bleeding is uncommon. Crohn's disease may also present with recurring perirectal fistulas or abscesses.

Terminal ileum is the most common site of involvement (**Figure 1**). Small bowel is involved in over three-quarters of cases, with concurrent involvement of colon in just under 50 percent. Crohn's disease may involve any part of the gastrointestinal tract.

Crohn's disease is a transmural process. Mucosal abnormalities include aphthous ulcers and intersecting linear ulcerations which produce a cobblestone pattern (**Figure 2**). Islands of hyperplastic mucosa between these ulcerations are termed pseudopolyps. Lymphedema and cellular infiltration produce thickening of the bowel wall. Adenopathy and fibrofatty proliferation may occur in the mesentery, along with phlegmons and abscesses. Sinus tracts and fistulas occur with communication between bowel loops or to the urinary tract or skin. Extraintestinal manifestations of Crohn's disease include sclerosing cholangitis, cholelithiasis, nephrolithiasis, sacroiliitis, uveitis, and erythema nodosum.

Histologically, cascating granulomas are seen only in about half of patients. Other helpful features are lymphoid aggregates, deep fissures, and the transmural nature of the disease.

Radiographic findings

Early radiographic findings include thickened edematous folds and aphthous ulcerations. Cobblestoning and pseudopolyps are well demonstrated. Spasm, stricture formation, and fistulas may be seen in affected segments.

Computed tomography (CT) is extremely useful in the evaluation of the extramucosal components of Crohn's disease. Symmetrical thickening of the bowel wall (**Figure 3**) due to submucosal edema is well seen. Mesenteric processes can easily be differentiated with CT (**Figure 4**). The low density tissue of fibrofatty infiltration contrasts with the ill-defined soft tissue mass of a phlegmon. Abscesses are characterized by their fluid density, and may contain bubbles of air (**Figure 5**). Fistulas and sinus tracts can be traced with CT, and mesenteric adenopathy is well seen. The extraintestinal manifestations of Crohn's disease also are well demonstrated. CT is extremely useful in guiding percutaneous management of abscesses.

Tuberculosis and yersinia can produce identical findings in the terminal ileum. Other diseases that may affect this segment include lymphoma, carcinoid, radiation enteritis, and ischemic bowel disease.

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A Clinical Moment With... Diabetes

Are hypoglycemic reactions dangerous?

Doctor, since I have been taking two injections of insulin daily with supplements of regular insulin when the blood glucose readings are above 150 mg/dl, I have been having insulin reactions shortly before mealtime two or three times a week. At these times, I perspire, my hands shake, and my heart beats fast. These symptoms are readily overcome by fruit juice or a glucose tablet. I have several questions about insulin reactions. I have heard that repeated hypoglycemic reactions may cause brain damage. Is that true? Also, if the reactions are more severe, what can I do to overcome them? Maybe close control of my glucose readings is not as desirable as I have been led to believe.

Close blood glucose control of diabetes usually means maintaining blood glucose test results between 80 and 140 mg/dl before meals and at bedtime, and a glycohemoglobin test within normal limits. Normal living activities, emotions, dietary indiscretions, and variable exercise will cause aberrations beyond these limits manifested by occasional hyperglycemia and hypoglycemic reactions. As the blood glucose concentration declines, a complex hormonal response occurs which includes release of epinephrine, glucagon, glucocorticoids, and growth hormone. Epinephrine release causes symptoms such as tachycardia, diaphoresis, and tremulousness — collectively called the adrenergic effect; these symptoms are particularly noticeable when the blood glucose falls rapidly. Central nervous system glucose deficiency or neuroglycopenia symptoms are headache, blurred vision, focal neurologic changes, and, ultimately, coma and death. Prompt restoration of glucose to a normal level usually leads to complete reversal of the symptoms, but prolonged hyperglycemia can cause irreversible neurologic damage.

As long as the symptoms or signs are of the adrenergic or early neuroglycopenic type, the use of oral glucose substances will usually bring about recovery within a few minutes. When a reaction is so severe as to cause confusion, inability to cooperate, or coma, the use of a glucagon injection or intravenous glucose infusion is mandatory. Recovery should occur within 20 minutes, but will vary with the duration of coma and the level of the blood glucose. Massaging the glucagon injection site with an alcohol sponge will speed the rate of utilization of the drug. The blood glucose level should be monitored if possible, and care should be taken not to overtreat the hypoglycemic state causing iatrogenic hyperglycemia. Reactions with recognizable adrenergic effect that can be readily treated with recovery are not dangerous. Close diabetic control should be continued.

Diabetic patients who do not manifest a recognizable adrenergic response due to advanced neuropathy, mental deficiency, concomitant drug therapy (e.g., beta-adrenergic blocking agents), or for any other reason, and who go into a neuroglycopenic behavior when hypoglycemia occurs,

should not attempt to attain close blood glucose control. The risk of brain damage and bodily injury are greater than the damage that will be produced by uncontrolled diabetes. Diabetic patients with an onset after 65 years of age will usually succumb to normal aging processes before the long-term complications of moderately controlled disease manifest themselves, and the stress of trying to maintain tight control hardly seems justified. Tight control of diabetes may also be hazardous for the patient who refuses to stop the use of alcohol. Moderation of diabetic control here is certainly justified.

A small group of patients for whom close self-monitoring of glucose is justified, are those individuals who lack confidence in self-management of their diabetes and who are constantly having anxiety symptoms they confuse with an adrenergic response. These people are almost always overweight and should document a low blood glucose test result (below 50 mg/dl) before consuming something to counteract the symptoms. In this type of person, it is usually a candy bar that they prefer to use to cope with the symptoms.

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Board of Physician Quality Assurance Actions

**In the matter of
Howlett Jackson, M.D.
before the
Maryland Board of
Physician Quality Assurance
Final decision**

On July 25, 1990, the Board of Physician Quality Assurance (the Board) issued a Notice of Intent to Deny Application for Reinstatement of Licensure to Howlett S. Jackson, M.D. (the Applicant) under the Maryland Medical Practice Act of the Health Occupations Article, *Annotated Code of Maryland* (HO) §14-205(a)(1)(iii). This section permits the Board to refuse the application of an applicant for reinstatement of his license in accordance with reasons that are grounds for action under HO 14-404,¹ specifically:

- (a)(22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this state.

In addition, the Board alleged that Applicant had not complied with the requirements for licensure reinstatement under HO §14-317 and in pertinent part, provides the following:

The Board shall reinstate the license of a physician who has failed to renew the license for any reason if the physician:

- (1) Meets the renewal requirements of §14-316 of this subtitle;
- (3) Submits to the Board satisfactory evidence of compliance with the qualifications and requirements established under this title for license reinstatements.

HO §14-316 sets forth the renewal requirements of the Act. It provides, *inter alia*:

- (c) Before the license expires, the licensee periodically may renew it for an additional term, if the licensee:
 - (3) Submits to the Board:
 - (ii) Satisfactory evidence of compliance with any continuing education requirements set under this section for license renewal.

The qualifications and requirements for continuing education reinstatement as set forth in COMAR 10.32.01.08C state:

- (1) A physician applying for renewal or re-instatement shall earn 50 credit hours of continuing medical education for each year of the period immediately preceding the licensee's renewal or re-instatement application, provided that no more than 150 credit hours may be required for a re-instatement application, and further provided that if a physician's license has been suspended or revoked by the Commission on Medical Discipline and is re-instated by the Board pursuant to Health Occupations Article §14-509, *Annotated Code of Maryland*, this physician shall earn a number of

hours which, together with any hours required pursuant to the Commission's Order, equals 150 credit hours.

- (2) The continuing medical education requirement may be satisfied as follows:
 - (a) Fifty credits earned for each year during the three-year period immediately preceding the licensee's renewal or re-instatement application toward the AMA Physician's Recognition Award, of which a minimum of 20 for each year of the registration period shall be in activities with AMA accredited sponsorship (Category 1);
 - (b) Fifty credits earned for each year during the three-year period immediately preceding the licensee's renewal or re-instatement application toward membership renewal in the American Academy of Family Physicians; or
 - (c) Fifty credits earned for each year during the three-year period immediately preceding the licensee's renewal or re-instatement application, in education programs sponsored by national medical societies and approved by the Board.
- (3) With the renewal application, a physician shall attest on a verified form to the fact that the physician has completed the continuing medical education requirement. Supporting documentation shall be retained for possible inspection by the Board for the succeeding six years.
- (4) The continuing medical education requirement shall apply to all renewal and re-instatement applications subsequent to the first renewal.

On December 13, 1990, a hearing was held before an Administrative Law Judge (ALJ). Present at the hearing were: the Applicant, counsel for Applicant, Norris Ramsey, Esquire; and Administrative Prosecutor for the Board, Robert J. Gilbert, Assistant Attorney General. At the hearing, the prosecutor withdrew the charge regarding the Applicant's failure to meet the continuing education requirements.

By letter dated February 19, 1991, the ALJ issued a Recommended Decision which included proposed Findings of Fact, proposed Conclusions of Law, and Recommendations. The parties were advised of their rights to file exceptions and present argument. No exceptions were filed and no argument requested. By letter dated April 4, 1991, the parties were advised by the Board that the Board would consider this case at its meeting on April 24, 1991 and issue a final decision.

At its meeting on Wednesday, April 24, 1991, the Board considered this case. On the affirmative vote of a majority of its full authorized membership, based on clear and convincing evidence, the Board issued the following Final Decision and Order.

At the hearing, the following documents were duly admitted into evidence:

<i>Joint Exhibit 1</i>	a copy of the medical records for Patient A.
<i>Joint Exhibit 1A</i>	original medical record for Patient A.
<i>Joint Exhibit 1B</i>	a copy of medical records for Patient A which was reviewed by Dr. Tilley.
<i>Joint Exhibit 2</i>	a copy of the medical records for Patient B.
<i>Joint Exhibit 3</i>	a copy of the medical records for Patient B.
<i>Joint Exhibit 3A</i>	original medical records for Patient B.

¹Health Occupations Article, Title 14, was renumbered effective January 1, 1991, pursuant to 11, Ch. 6, Acts 1990. All statutory cites are to the new numbers.

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<i>Joint Exhibit 3B</i>	a copy of medical records for Patient B which was reviewed by Dr. Tilley.
<i>Joint Exhibit 4</i>	a composite drug list for Patient B.
<i>Joint Exhibit 5</i>	a copy of the medical records for Patient C.
<i>Joint Exhibit 5A</i>	original medical records for Patient C.
<i>Joint Exhibit 5B</i>	a copy of medical records for Patient C which was reviewed by Dr. Tilley.
<i>Joint Exhibit 6</i>	a composite drug list for Patient C.
<i>Joint Exhibit 7</i>	an amended copy of the Notice of Intent to Deny Application for Reinstatement of Licensure Under the Maryland Medical Practice Act.
<i>State Exhibit 1</i>	the curriculum vitae of Larry Tilley, M.D.

Larry Tilley, M.D. testified for the state.

<i>Appellant Exhibit 1</i>	letter from Jack L. Mason, Ph.D., assistant dean for continuing medical education at the School of Medicine, University of Maryland at Baltimore, dated August 26, 1990.
<i>Appellant Exhibit 2</i>	letter from Gunther D. Hirsch, M.D. to the Maryland Board of Medical Examiners, dated December 12, 1990.
<i>Appellant Exhibit 3</i>	letter from Ivan I. Rotkovitz, P.D. to the Board of Medical Quality Assurance, undated.
<i>Appellant Exhibit 4</i>	letter from Percival Smith, M.D. to the Board of Medical Quality Assurance, dated December 12, 1990.
<i>Appellant Exhibit 5</i>	certification that Applicant completed 15 hours of Category 1 CME on April 22-23, 1987, from the University of Maryland School of Medicine Program of Continuing Education.

Appellant testified on his behalf.

Findings of fact

The Board, by clear and convincing evidence, finds:

1. Applicant was originally granted licensure to practice medicine in the State of Maryland on or about August 1977.
2. As a result of an investigation by Division of Drug Control (DDC), forwarded to the Committee on Drugs (COD), forwarded then to the Commission on Medical Discipline, and then to the Medical and Chirurgical Faculty, on or about March 30, 1989, the Board requested that the Peer Review Management Committee (PRMC) conduct a practice review of the Applicant's practice.
3. Larry Tilley, M.D. participated in the peer review of this case under the auspices of the PRMC, and the original medical records contained certain laboratory reports, demographic information and slips of paper which were not contained in the copies of the medical records reviewed by Dr. Tilley.
4. Applicant failed to renew his medical license in 1988 as

required, and he continued to practice medicine without a valid license until May 29, 1990.

5. The testimony of Applicant with regard to his lack of awareness of any possible abuse issues in the prescription of narcotic analgesic medications of Patients A and C was not credible.
6. The testimony of Applicant with regard to this method of recordkeeping was not credible.
7. The testimony of Dr. Tilley, with regard to the care rendered to Patients A, B, and C, and the recordkeeping for those patients, was credible and presented substantial evidence to refute the testimony of Applicant with regard to his care and recordkeeping for these patients.

The care rendered to Patient A by Applicant:

8. Patient A is a 36-year-old male who received treatment from Applicant from October 1985 through May 1990 for "lumbar discogenic disease" or "low back pain," and, at times, for chelitis, laryngitis, and bronchitis.
9. Applicant's long-term prescribing of narcotic analgesic pain medications for Patient A was not within the appropriate standard of care for the practice of medicine in the State of Maryland.
 - a. The only references to diagnostic testing contained in the medical record for Patient A are scant and do not indicate that any substantial diagnostic work-up was conducted:

straight leg raising + 25 degrees on right 40 degrees on left, can flex trunk 60 degrees.

neuro - DTR 2+ arms 0 at ankles and knee U/A ne

Pt. was in an auto accident yesterday which made his back feel much worse. Pt. has pain and intermittent paresthesia in right leg without urinary or fecal incontinence. SLR + 20 degrees bilaterally. Flexion pain 30 degrees. DTR's without legs.

Patient complains of severe back pain and excruciating pain in his right leg. Pain is helped slightly by Percodan. Patient has been mostly on bed rest for the last several days. Back is nontender. Straight leg raising is positive at 25 degrees on the right and 50 degrees on the left. Patient is markedly decreased active range of motion of the trunk. Patient got on the examining table with much difficulty and patient walks with limp.

Impression in lumbar disc degenerative disease, exacerbated by lumbosacral strain.

Plan hot packs and ultrasound of the back daily. Percodan q. 4-6 h. pm. Return to clinic in one week.

Pt. is going out of town for a week and will need prescription. Pt. continues to have excruciating back pain. Pain not helped much by TENS or back brace. Pain helped significantly by thermophore. Back minimally tender. Markedly decreased active range of motion due to pain. Percodan #50. Darvocet N-100. Q4-6 #50. Erythromycin ointment.

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- b. Over the five-year course of treatment, there are occasional entries in the medical records about the physical examination and other things, but the only treatment discussed in the medical records was the prescription of narcotic, analgesic pain medications, i.e., Tylox, Percodan, Percocet, and Darvocet.
 - c. The standard of care for the prescription of narcotic medication in the State of Maryland is to prescribe narcotics for intractable pain syndromes in quantities that do not suggest abuse by the patient, recognizing some degree of latitude in how much pain medication each individual needs.
 - d. During the relevant treatment period reviewed for this proceeding, Applicant prescribed Percodan, a narcotic, 72 times; Percocet, a narcotic, seven times; Darvocet-N 100, a narcotic, 34 times; and Tylox, a narcotic, ten times.
 - e. During the relevant treatment period reviewed for this proceeding, Applicant prescribed Percodan and Darvocet-N 100 at the same time on 14 occasions.
10. Applicant's long-term prescribing of narcotic analgesic pain medications for Patient A, in the absence of pursuing other therapeutic modalities, was not within the standard of care for the practice of medicine in the State of Maryland for the treatment of lumbar discogenic disease.
- a. The medical record indicates that Patient A had been previously diagnosed in 1985 as having lumbar discogenic disease.
 - b. The standard of care for the treatment of lumbar discogenic disease requires an evaluation of the etiology of the patient's back pain through diagnostic testing, some appropriate therapy (i.e., physical therapy, medication, non-steroidal, anti-inflammatory drugs, exercise programs), a possible consultation with an orthopaedic surgeon or neurosurgeon when appropriate, and possible referral to a rehabilitation specialist for some other kind of job training.
 - c. Applicant's testimony that Patient A had no medical insurance, could not afford extensive testing and treatment, and only wanted some pain relief so that he could continue to work was not credible as a justification for prescribing the quantity of narcotic medication involved in this case.
 - d. Applicant did not pursue diagnostic studies and other therapeutic modalities. The only treatments described in the medical records are the prescription of narcotic analgesic medications and occasional use of hot packs and ultrasound.
 - e. Although references are made in the medical record of magnetic resonance imaging (MRI), myelogram and evaluations by other physicians due to trauma, there are no reports of any of those tests or evaluations contained in the medical record other than a consultation report from Harold M. Hagen, M.D., radiologist, regarding an upper gastrointestinal (GI) tract evaluation.
 - f. Applicant was aware that Patient A, as a veteran, could have obtained the appropriate testing and additional treatment for discogenic disease from the Veterans' Administration (VA) at little or no cost to him, and yet did not make any such referral for him.
11. Applicant's long-term prescribing of narcotic-containing pain medications, in the quantities indicated, was inappropriate and below the standard of care for the practice of medicine in the State of Maryland.
- a. On 7/2/87, the patient received a prescription for Percodan, 60 tablets, and Darvocet-N, 60 tablets, and returned one week later, on 7/9/87 and received another prescription for Percodan, 60 tablets, and Darvocet-N, 60 tablets.
 - b. The issue of the additional prescription on 7/9/87 would indicate that the prior prescription had been used up, exhausted.
 - c. The use by a patient of 120 tablets in a one-week period would mean that the patient had taken 15 tablets per day of the medication, which is an inconceivable amount of medication for a patient such as Patient A to require.
 - d. The Applicant, in retrospect, recognized that his use of narcotic analgesic medication for Patient A was excessive.
12. Long-term usage of narcotic medications listed in Joint Exhibit 2 can produce drug dependency on the part of the patient.
13. Applicant knew, or should have known, that the patient was addicted to, or was becoming addicted to, the medications listed in Joint Exhibit 2, or was using them for other than therapeutically appropriate reasons.
- a. Applicant made several references in the medical records that he had spoken with the patient regarding the possible abuse of the medications. And, notwithstanding, he continued to prescribe large amounts of narcotic medications for him.
 - b. By Applicant's own testimony, he had worked in areas where there was rampant drug abuse, and he was aware of the proclivity of patients to abuse drugs such as Percodan, Darvocet-N, etc.
 - c. Patient A had presented to Applicant many of the same stories which are known to be used by abusers of medications: he had lost the prescription, the prescription was stolen, he was going out of town and needed additional medication, he did not want to pursue a remedy for the cause of the pain but preferred just to have medication in order to enable him to continue to work, etc.
 - d. Applicant's testimony that he had no reason to believe

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that Patient A was abusing the narcotic prescriptions given to him was not credible.

14. Applicant administered an injection of B₁₂ 1,000 mg IM for no apparent reason on May 14, 1988.

- a. The medical record for May 14, 1988

Pt. wants B₁₂ injection, going out of town. Back - markedly decreased active ROM. Imp. (1) lumbar discogenic disease. P - F/V at VAH. B₁₂ 1,000 mg IM.

- b. Vitamin B₁₂ is utilized only for the treatment of pernicious anemia.
c. It is below the standard of care to give a patient an injection of B₁₂ just because the patient asked for it.
d. There is no indication in the medical record that Patient A suffered from pernicious anemia.
e. Applicant, himself, recognized that vitamin B₁₂ usage for other than pernicious anemia has no particular medical benefit, but is of no particular harm.

15. The Applicant's medical record in regard to Patient A is deficient and not within the appropriate standard of care.

- a. An adequate medical record should contain the background information from the past history and the family history, and the history of the particular problem that is presented; the physical examination findings; results of diagnostic testing and laboratory testing; an assessment and a differential diagnosis; and a treatment plan.
b. It is especially important for the primary health care provider to maintain complete and adequate records for patients, and the Applicant was the primary health care provider for Patient A.
c. The medical record entries for most of the visits do not document a physical examination or evaluation performed by the Applicant to substantiate the low back pain or the Applicant's impression of the patient as having lumbar discogenic disease. Entries for 8/4/87, 8/17/87, 8/25/87, 10/7/87, 10/14/87, 10/15/87, 10/29/87, 11/5/87, 11/30/87, 12/13/87, 1/5/88, 4/27/88, 5/14/88, 6/2/88, 6/4/88, 8/10/88, 4/10/89, 5/1/89, 1/8/90, 1/22/90, 2/12/90, 4/12/90, 4/30/90, and 5/5/90 are examples of lack of documentation of a physical examination or evaluation.
d. The medical record does not contain sufficient historical information on the patient and other data in regard to the physical condition of the patient such as height, weight, blood pressure, pulse rate, the source of his pain, when the pain occurs, and under what circumstances his pain occurs. Entries for 8/4/87, 8/17/87, 8/25/87, 10/7/87, 10/14/87, 10/15/87, 10/29/87, 11/5/87, 11/30/87, 12/23/87, 1/5/88, 4/27/88, 5/14/88, 6/2/88, 6/4/88, 8/10/88, 4/10/89, 5/1/89, 1/8/90, 1/22/90, 2/12/90, 4/12/90, 4/30/90, and 5/5/90 are examples of lack of documentation of

historical information on the patient and other data in regard to the physical condition of the patient.

- e. The medical records do not contain evidence that Applicant attempted to verify his assessment of the lumbar discogenic disease.
i. There is no documentation in the record that Applicant ever ordered any radiographic or neurological testing to verify his continuing assessment of the patient's condition.
ii. There is no documentation in the medical record that Applicant ever requested or received medical records regarding testing by consulting physicians other than one consultation report from a radiologist regarding an upper GI study.
iii. The medical record contains entries that the patient had used a TENS (transcutaneous electrical nerve stimulation) unit (7/2/87 and 2/10/88); had nerve conduction studies at the VA Hospital (4/27/88); and was scheduled for an MRI, myelogram, and CAT (computer-assisted tomography) scans (9/5/89, 9/19/89, 11/14/89, 12/14/89, 5/5/90, and 5/23/90).
iv. The medical records do not contain any of the reports of those tests or reports from any consulting physician verifying that the tests were either scheduled or performed.
v. The medical records do not contain any test records from either the VA Hospital or the physician or clinic that provided the patient with the TENS unit.
f. It is important that medical records be kept in such a form that a successor physician could read an entry and have an idea of the status of the individual on that particular day and what therapy was intended for the future.
i. The medical records are deficient in that they are so insubstantial that it would be difficult for any successor physician to determine the significance of the entry or purpose of the visits for 8/17/87, 10/3/87, 10/7/87, 11/5/87, 2/23/88, 3/3/88, 6/2/88, 6/4/88, 8/10/88, 5/30/89, 7/20/89, 8/3/89, 8/15/89, 1/8/90, 1/22/90, 2/12/90, 4/12/90, and 4/20/90.
ii. The medical entry for 10/3/87 states only "patient has a great deal of low back pain."
iii. The medical entry for 11/5/87 states only "patient having cont. severe back pain."
iv. Medical entries for 2/23/88, 3/3/88, 6/2/88, 8/10/88, 1/8/90, 1/22/90, and 4/30/90 contain only prescription notations.
g. The medical record is deficient because, in several entries, there is no documentation by Applicant as to his rationale for prescribing narcotic analgesic pain medications.
i. Medical entries for 7/30/87, 10/7/87, 2/23/88, 3/3/88,

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6/2/88, 8/10/88, 1/8/90, 1/22/90, and 4/30/90 indicate narcotic analgesic pain medications were prescribed.

- ii. On each of these occasions, Applicant did not state, in the medical entry, the rationale for prescribing the medications of the specific condition that the patient experienced which justified the prescriptions.
- iii. The standard of care in prescribing drugs is to indicate the quantity of drugs prescribed in the medical record.
- iv. Applicant did not record the quantity of narcotic analgesic pain medications prescribed for the patient in the entries for 10/16/85, 12/27/85, 2/8/86, 2/17/86, 5/5/86, 5/12/86, 12/17/86, and 7/30/87.

The care rendered to Patient B by Applicant:

- 16. Patient B is a female patient, age 39, who began receiving treatment from Applicant in November 1985 and continued through April 1990, primarily for asthma, obesity, and arthritis. She also received treatment for other ailments such as anemia, anxiety, and psoriasis.
- 17. Between July 1987 and April 1990, Applicant treated the patient primarily with prescriptions for asthma medication and with anorectic medications, such as Adipex-P, Prelu 2, and Fastin. All treatment by Applicant was rendered in the form of office visits.
- 18. Joint Exhibit 4 is hereby incorporated by reference as a comprehensive list of the prescriptions issued to Patient B by Applicant from November 23, 1985 through March 26, 1990.
- 19. Applicant's treatment of Patient B's obesity was inappropriate.
 - a. The appropriate standard of care for the treatment of obesity would include documentation of the patient's height and weight, how much weight loss would be contemplated, and a program to lose the weight, which could include a specified diet to follow, an exercise program, and possibly anorectic drugs for a brief period of time.
 - b. During the four and one-half year period of treatment, Applicant treated the patient primarily by prescribing anorectic drugs as Adipex-P, Prelu 2, and Fastin.
 - c. The medical record does not contain any indication that the patient complained of obesity at the time of the initial examination (11/23/85) when Adipex was prescribed.
 - d. Over the course of a four and one-half year treatment with various anorectic drugs, the patient's weight varied only about 12 pounds.
 - e. The *Physicians' Desk Reference* states that anorectic medications are to be used for brief periods of time, i.e., two to four weeks.
 - i. The appropriate standard of care for use of anorectic drugs is for short intervals, as they are potentially habituating to the patient.
 - ii. A patient may develop a tolerance and a psychological addiction to the drugs.
 - iii. Anorectic drugs are also stimulants and sometimes can have an adverse affect in their stimulating characters.
 - f. The patient reported that an anorectic drug (Fastin) no longer curbed her appetite.
 - g. Applicant continued to prescribe Fastin to the patient on several additional occasions: 8/29/89, 10/24/89, 12/19/89, 12/27/89, 1/23/90, and 3/26/90.
 - h. Applicant's prescribing of anorectics was inappropriate in view of the patient's complaints of anxiety.
 - i. Anorectic drugs have the ability to cause some degree of anxiety or a hyperactive state, and they may contribute to an anxiety situation.
 - ii. On 8/29/89 and 12/19/89, the patient complained of anxiety and, yet, Applicant continued to prescribe anorectic medications for her.
 - i. Applicant's actions in monitoring the patient's blood pressure during the period in which the Applicant prescribed the anorectic medications was inappropriate.
 - i. Because one of the side reactions of anorectic drugs is the possible elevation of blood pressure, the standard of care is that any patient receiving anorectic medications have his/her blood pressure monitored at each office visit or in a timely fashion.
 - ii. Blood pressures for the patient were not recorded on 7/9/87, 8/6/87, 9/10/87, 8/29/88, and 9/13/88.
 - j. Applicant did not prescribe or did not document that he had prescribed a particular diet for the patient.
 - i. In treating a patient for obesity, the standard of care is to outline a diet program for the patient to follow — either one specifically written for the patient or a commercially available diet such as the Pritikin diet — which would be prescribed and written in the record.
 - ii. Applicant did not prescribe a specific diet for the patient to follow.
 - iii. On February 14, 1989 and March 26, 1990, Applicant noted only that the patient was to be placed on 1,000-2,000 calorie diet or was referred to the "Pritikin Program text," but no specific diet regimen was listed in the medical record.
 - iv. It is important, in the overall management of an obesity problem, to have a dietary program to follow and be monitored.
 - v. Applicant did not demonstrate that a specific dietary regimen was prescribed for this patient or that her obesity problem was properly monitored.

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- vi. Applicant's testimony that he regularly advised the patient to eat fewer calories and to exercise was not credible or substantial evidence that he placed her on a diet regimen or monitored her within the appropriate standard of care.
20. Applicant's evaluation and treatment of the patient's arthritis was inappropriate.
- The standard of care for the diagnosis and treatment of arthritis requires historical information which would suggest some type of joint problem; physical examination evidence by description of the joints; blood studies used for confirmation; and x-rays.
 - There was not sufficient documentation of the arthritis diagnosis in the patient's medical record.
 - Throughout the relevant treatment period (4/13/88, 5/13/88, 6/7/88, 8/29/88, 12/6/88, 12/20/88, 3/16/89, 4/25/89, 8/29/89, 10/24/89, 11/21/89, 12/19/89, 1/23/90, and 4/26/90), Applicant continued to assess the patient as having arthritis.
 - The medical record does not document any physical examinations of the patient regarding the diagnosis of rheumatoid arthritis.
 - Although Applicant often refers to "joint pain" suffered by the patient, there are only a few entries in the medical record which make reference to particular areas in which the patient suffered distress:

3/15/88: Pt. having problem with legs aching. Sometimes has to walk with a limp... Pt. having pain mostly in right knee and hip, feet swollen in a.m. Pt. feels tired all the time. Right knee not swollen erythematous or tender. Right elbow not swollen, tender, patient can extend left elbow to only about 160 degrees without difficulty.

8/29/88: Pt. having a great deal of problem with her hands especially in the a.m. Both wrists slightly swollen and tender not erythematous...

Undated: Patient complains of having some increased pain in her right shoulder and also the right hip over the last several days. The patient notes that she has had increased pain in the shoulder and hip since she started having her gold shots every other week instead of weekly...

3/26/90: ...The patient is having some hip pains, but they are being fairly well relieved by Motrin. The patient is now getting gold injections once monthly...
21. Applicant's medical record in regard to the treatment of Patient B is deficient and not within the appropriate standard of care.
- An adequate medical record should contain the background information from the past history and the family history, and the history of the particular problem that is presented; the physical examination findings; results of diagnostic testing and laboratory testing; an assessment and a differential diagnosis; and a treatment plan.
 - It is especially important for the primary health care provider to maintain complete and adequate records for patients, and Applicant was the primary health care provider for Patient B.
 - Applicant's medical entries for Patient B primarily consist of: the patient's chief and secondary subjective complaints; a diagnosis of any combination of asthma, arthritis, obesity and/or anxiety; and prescriptions of asthmatic drugs, anti-anxiety drugs, and anorectic medications.
 - The appropriate standard of care requires that, in the case of anemia, the record should contain documentation to support the diagnosis.
 - The medical record entry for 3/15/88 indicates that the patient was diagnosed as having anemia, and there is nothing in the medical record to suggest any physical symptoms or laboratory testing to substantiate this assessment.
 - The standard of care for diagnosis and treatment of obesity requires that the record document a weight reduction plan.
 - Applicant did not describe with specificity the weight reduction plans he prescribed for this patient.
 - The standard of care requires that the patient's age and height be listed in the medical record.
 - Although Applicant did list the patient's age (39 years) in the medical record, there is no recordation of her height.
 - The primary care giver should have information about the patient's conditions that are being treated by another physician in order to maintain an up-to-date record.
 - Although Applicant made several references to Dr. Marcus in this patient's record (Dr. Marcus is the physician from whom the patient received gold injections), there is only scant correspondence from Dr. Marcus contained in the medical record kept by Applicant (prescription slips and notations of complete blood count (CBC) results). There is no report or analysis of the patient's condition from Dr. Marcus contained in the medical record.
 - Several office visit entries for this patient contain either no information at all (3/29/88) or contain scant information which falls below the standard of care iterated above with regard to adequate recordkeeping (8/29/88, 9/20/88, and 1/23/90).
- The care rendered to Patient C by Applicant:*
22. Patient C began seeing Applicant in March 1987 with a complaint of low-back pain radiating to the right leg. The diagnosis was lumbar discogenic disease, and she continued to be treated by Applicant through November 1988. This patient was also treated by Applicant for

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- migraine headaches, depression, and anxiety. All of the treatment was in the form of office visits.
23. From May 21, 1987 through October 28, 1987, Applicant prescribed Percodan on 18 occasions (760 pills plus three prescriptions for no amounts listed).
 24. From January 6, 1988 through November 6, 1988, Applicant prescribed Fiorinal #3 on 22 occasions (996 pills plus two prescriptions with no amounts listed).
 25. Notwithstanding the fact that x-ray studies of the patient's lumbosacral spine were conducted at Harford Memorial Hospital in August 1987 to support the diagnosis of lumbosacral discogenic disease, the standard of care with regard to prescribing a narcotic analgesic pain medication is violated by the quantity of medications prescribed by Applicant for this patient.
 26. Percodan and Fiorinal #3 are narcotic analgesic medications.
 27. From 7/2/87 through 8/1/87, Applicant prescribed approximately 330 tablets of Percodan for this patient; in a five-week period of time (7/21/88 through 8/27/88), the Applicant prescribed 280 tablets of Fiorinal #3 for this patient which violates the standard of care.
 28. Applicant's testimony that he had no reason to believe that this patient was abusing the prescribed narcotic and controlled substances was not credible.
 29. Applicant's treatment of the patient's migraine headaches was inappropriate.
 - a. The appropriate standard of care in the diagnosis and treatment of migraine headaches requires an evaluation of the patient's complaint of headaches, an attempt to determine an etiology, a physical examination, specifically including certain neurological evaluations, and appropriate therapy for the specific case.
 - b. Although Fiorinal #3 is sometimes used for severe migraine headaches, the quantities utilized by Applicant for this patient violated the standard of care.
 - c. On 1/25/88, the date that the patient first complained of migraine headaches, there is no evidence in the medical record of any physical examination having been performed at all, other than a patient charge slip with "brief examination" circled and, thus, the diagnosis of tension or vascular headaches and prescribing of Fiorinal #3 at that time was below the standard of care.
 30. Applicant's medical record in regard to this patient is deficient and not within the appropriate standard of care.
 - a. An adequate medical record should contain the background information from the past history and the family history, and the history of the particular problem that is presented; the physical examination findings; results of diagnostic testing and laboratory testing; an assessment and a differential diagnosis; and a treatment plan.
 - b. The medical records for this patient did not meet the standard of care in that a substantial number of entries (7/2/87, 7/8/87, 7/15/87, 8/1/87, 8/31/87, and 10/10/87) do not adequately deal with the patients' complaints, a physical examination, or therapeutic modality.
 - c. The standard of care for medical records requires that a patient who is being followed for low-back pain, should contain documentation of the source of the pain, radiation, and activities which aggravate or improve the pain, and the Applicant's medical records for this patient do not contain this information.
 - d. The medical entries for 7/2/87, 7/8/87, 7/15/87, 7/22/87, 8/1/87, 8/31/87, 9/30/87, and 10/10/87 do not contain any documentation that Applicant performed a physical examination of the patient to verify his diagnosis of lumbar discogenic disease.
 - e. The standard of care in the treatment of patients such as Patient C requires that diagnostic studies sufficient to elucidate a diagnosis be made: x-rays, computed tomography (CT) scans, MRIs, and, possibly, neurosurgical or orthopaedic surgeon consultations.
 - f. The medical records for this patient document that an x-ray study of her lumbosacral spine was performed at Harford Memorial Hospital on August 4, 1987.
 - g. The medical record indicates that the patient received heat pack and electrical stimulation treatments on 7/2/87, 7/8/87, 7/15/87, 7/22/87, 7/28/87, and 8/1/87 and, although the record does not document the area in which the treatments were applied or the nature and extent of those treatments, it can be assumed that the treatments were applied to the lower back as that is the area in which all of the patient's complaints had been.
 - h. The medical record entries for July 2, 1987 and July 28, 1987 are below the standard of care for medical recordkeeping in that there is no subjective/objective assessment of the patient's condition.
 - i. The medical record entries for July 15, 1987, August 1, 1987, and October 10, 1987 are below the standard of care for medical recordkeeping as they do not specify the number of tablets or capsules of medication. The standard of care requires that the number of tablets or capsules of medication be listed in the medical record so at future reference to that entry one would know how many items of the medication a patient was given.
 - j. The fact that Applicant did not provide full documentation concerning assessments of the patient's complaints does not, in and of itself, render the recordkeeping by the Applicant below the standard of care. The recordkeeping, as a whole, falls below the appropriate standard of care.

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General findings with regard to the care of Patients A, B and C:

31. The recordkeeping for each of the patients is below the standard of care due to incompleteness and, thus, could prevent a subsequent physician from providing a continuum of care for the patients.
32. The prescribing of the unusually large number of narcotics and other controlled substances to Patients A and C is below the standard of care.
33. With regard to the care of Patients A and C, the care rendered to them by Applicant was below the standard of care in that the only treatment modality chosen was the use of narcotics and some minimal type of physical therapy given in the office. No other modalities were entertained, and no other diagnostic studies were done other than one back x-ray for Patient C.

Conclusions of law

On the basis of the above Findings of Fact, the Board, as a matter of law, concludes that a reason for denying Applicant's application for reinstatement is ground §14-404(a)(22), i.e., "fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital or any other location in this state."

The Board further concludes that Applicant did meet the continuing education requirements for reinstatement of his license.

Order

It is this 14th day of May 1991, by the Board of Physician Quality Assurance

ORDERED that the Applicant's application for reinstatement of his medical license under the Maryland Medical Practice Act be DENIED; and be it further

ORDERED that the charges based on failure to meet continuing education requirements for reinstatement are DISMISSED; and be it further

ORDERED that Applicant may petition the Board, through its Settlement Conference, for reinstatement of his license when he can demonstrate he has successfully completed a Board approved accredited training program; and be it further

ORDERED that this is a final order and as such is considered a public document pursuant to State Government Article, §10-617(h) *et seq.*

ISRAEL H. WEINER, M.D., Chairperson
Maryland Board of Physician Quality Assurance ■

In the matter of Omar K. Omland, M.D. before the Maryland Board of Physician Quality Assurance Consent order

On April 24, 1991, the State Board of Physician Quality Assurance (the Board), pursuant to its authority under *Md. Health Occ. Code Ann.*, §14-404, charged Omar K. Omland, M.D. (the Respondent) under *Md. Health Occ. Code Ann.* §14-404(a)(3)¹ with charges under the Maryland Medical Practice Act. The pertinent provisions of §14-404 provide:

- (a) Subject to the hearing provisions of §14-405 of this subtitle, the Board, on the affirmative vote of a majority of its full authorized membership, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
 - (3) Is guilty of immoral ... conduct in the practice of medicine;

On May 22, 1991, a Settlement Conference (the Conference) was held. As a result of discussions at the Conference, Respondent agreed to enter into a Consent Order and the Conference recommended that the Board accept a Consent Order as a resolution of this case. At the Board meeting on Wednesday, June 26, 1991, by an affirmative vote of a majority of the full authorized Board who considered this case, the Board voted to enter into the following Consent Order.

Findings of fact

1. At all times relevant to these charges, Respondent was and is licensed to practice medicine in the State of Maryland.
2. Respondent has been practicing medicine in Montgomery County, Maryland since 1979 and has been a physician since 1972.
3. Respondent maintains a private office for the practice of medicine at 8021 Horseshoe Lane, Potomac, Maryland

¹ The basis of the allegations against Respondent was conduct that occurred between February 1984 and September 1986. The applicable statute in effect at that time was *Md. Health Occ. Code Ann.* §14-504(3) which provided:

Subject to the hearing provisions of §14-505 of this subtitle, the Board, on the affirmative vote of a majority of its full authorized membership, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee is guilty of immoral conduct in the practice of medicine.

Section 1, Chapter 109, Acts of 1988, effective July 1, 1988, recodified former §14-504(3) as §14-504(a)(3), and inserted the following underlined words in the existing statute:

Is guilty of immoral or unprofessional conduct in the practice of medicine.

Section 11, Chapter 6, Acts of 1990, effective January 1, 1991, renumbered §14-504(a)(3) as §14-404(a)(3).

Board of Physician Quality Assurance Actions

20854. Respondent's practice is located in an office in his home.

4. Respondent's practice is limited to psychiatry.
5. Patient A was a patient of Respondent's from February 1984 to September 1986. Patient A initially sought treatment from Respondent for exhaustion and symptoms of depression after her father's death. Patient A was married and living with her husband when she first sought treatment from the Respondent.
6. During treatment sessions in 1985 and 1986, Respondent engaged in immoral conduct with Patient A by telling her that he loved her, and hugging and kissing her.
7. Respondent engaged in immoral conduct in November of 1985, when he met with Patient A in a restaurant and referred to this meeting as a date. Patient A met with Respondent at the restaurant under the belief that it was part of her psychiatric treatment.
8. Respondent engaged in immoral conduct when, during psychiatric appointments with Patient A, from February of 1986 through September of 1986, he had sexual contact with Patient A and permitted Patient A to have sexual contact with him.
9. Respondent engaged in immoral conduct in March of 1986 when Patient A advised him that she wished to wean herself from the prescription drugs that Respondent was prescribing to her. Respondent refused to assist Patient A in weaning her from the prescription drug Xanax. Although Patient A was suffering from clear symptoms of withdrawal, Respondent engaged in immoral conduct when he failed to provide appropriate medical assistance to Patient A during her withdrawal from Xanax.
10. The relationship between a psychiatrist and his/her patient is one of trust in which the patient is dependent, vulnerable, and relies on the physician. The patient in this relationship can easily be exploited and all caution should be exercised, by the physician, not to exploit this trust.
11. There is no valid medical treatment that involves sexual contact between a patient and treating psychiatrist during the course of psychiatric therapy sessions.
12. Sexual contact with a patient by a psychiatrist is exploitive and can harm the patient. Sexual contact with a patient by a psychiatrist is immoral conduct in the practice of medicine.
13. Respondent violated the trust and dependency placed in him by Patient A.
14. Respondent's conduct with Patient A was immoral and violated professional standards governing the appropriate practice of psychiatry in Maryland.
15. A standard for the delivery of quality surgical and medical care is NOT to engage in sexual contact with patients.
16. A standard for the delivery of quality surgical and medical care is not to violate the trust of a patient.
17. A standard for the delivery of quality surgical and medical

care is that a physician is required to assist his or her patient when the patient requests assistance.

18. As a medical review committee, as defined in §14-501 of the Health Occupations Article of the *Annotated Code of Maryland*, and as the regulatory Board governing the practice of medicine in Maryland, the Board is an appropriate peer review body to determine whether a licensee has failed to meet appropriate standards for the delivery of quality medical and surgical care in Maryland.

Conclusions of law

Based upon the foregoing Findings of Fact, the Board concludes, as a matter of law, that the Respondent is guilty of immoral conduct in the practice of medicine.

Order

Based upon the foregoing Findings of Fact and Conclusions of Law, it is this 11th day of July 1991, by an affirmative vote of the majority of the full authorized membership of those members of the Board of Physician Quality Assurance of Maryland who considered this case, hereby

ORDERED that Respondent's license to practice medicine in the State of Maryland is SUSPENDED for a period of three years, beginning July 4, 1991; and it is further

ORDERED that, on October 2, 1991, the SUSPENSION of Respondent's license to practice medicine in the State of Maryland will be STAYED and Respondent will be placed on PROBATION subject to the following conditions for a period of three years beginning October 2, 1991:

1. Respondent shall earn 75 credit hours of continuing medical education annually, of which a minimum of 45 credit hours shall be in activities with AMA accredited sponsorship (Category I) and a minimum of 25 credit hours shall be in the field of psychiatry as approved by the Board's Settlement Conference (the Conference). Within seven days of receipt of continuing medical education credit hours, Respondent shall send a copy of the certificate of attendance to the Board, attention: Stephen H. Johnson, Chief Case Manager.
2. In addition to the continuing medical education requirements listed in paragraph one above, Respondent shall attend Grand Rounds at a psychiatric facility on at least ten occasions during the probationary period. Prior to attending Grand Rounds, Respondent shall notify the Board, in writing, of the facility where Respondent would like to attend Grand Rounds. Respondent's attendance at a specific facility is subject to the Board's approval. Although continuing medical education credit hours may be awarded for attendance at Grand Rounds, the credit hours may *not* be applied toward satisfying the requirements of paragraph one above. Any credit hours received for attendance at Grand Rounds will be in addition to the

Board of Physician Quality Assurance Actions

75 credit hours of continuing medical education required annually.

3. Respondent shall attend the Harvard University Psychiatric Review Course sponsored by the Harvard Medical School in the spring of 1992 at his own expense. Within seven days of completion of the course, Respondent shall send a copy of the certificate of attendance to the Board, attention of the Chief Case Manager. Respondent may petition the Board to allow Respondent to attend another comparable course if, prior to January 1, 1992, Respondent notifies the Board, in writing, of the review course that Respondent would like to attend and Respondent provides a comprehensive description of the course to the Board. Respondent's attendance at a course other than the Harvard Review course is subject to the Board's approval. Continuing medical education credit hours received as a result of attending the course may be applied toward the 25 credit hours in the field of psychiatry as required in paragraph one above.
4. On or before August 15, 1991, Respondent shall submit to a psychiatric re-evaluation by John R. Lion, M.D. In addition, Respondent shall be re-evaluated by Dr. Lion at the end of each year of this probation. Respondent shall pay all costs associated with the evaluations. Respondent shall sign a release authorizing Dr. Lion to send copies of his reports to the Board. Respondent shall sign a release authorizing the Board to release the reports to the supervisory physicians, the peer reviewers, and Respondent's therapist. The Respondent shall receive a copy of each of these reports.
5. Respondent shall participate in psychotherapy with a psychiatrist (therapist) selected by Respondent from a list submitted by Dr. Lion to the Board.
 - a. The therapist will see Respondent for therapy on at least a weekly basis, and more often if the therapist thinks it is appropriate. Respondent must follow the recommendations for the number of therapy sessions made to Respondent. If the therapist believes that therapy should be terminated, then he/she can so notify Dr. Lion. Dr. Lion will then re-evaluate the Respondent and make a recommendation concerning continued therapy to the Board. The Board must approve the termination of therapy before the change becomes effective.
 - b. Respondent shall be responsible for all costs and expenses incurred in therapy.
 - c. The therapist shall submit monthly reports to the Suburban Maryland Psychiatric Society Peer Review Committee (SMPS PRC), attention: Ann Birk, M.D., indicating only that Respondent is attending the therapy sessions as recommended.
 - d. In the event that Respondent terminates therapy prior to discharge by the therapist, the therapist shall immediately notify the SMPS PRC that Respondent has terminated therapy.
 - e. In the event that the therapist has reason to believe that Respondent is a danger to himself or others, the therapist will immediately notify Dr. Birk of SMPS PRC.
 - f. In the event that the initial therapist is unable to continue treatment, through no fault of Respondent's, the therapist must immediately notify SMPS PRC. SMPS PRC, within ten days of receipt of the notice, shall present Respondent with a list of three approved psychiatrists from whom Respondent must immediately select another therapist. The new therapist must inform SMPS PRC in writing that he/she agrees to perform all duties required under this Order.
6. When Respondent resumes his practice on October 2, 1991, Respondent agrees to attend weekly supervision sessions under the supervision of one or two of the following psychiatrists:
 - (a) Larry Sack, M.D., Washington, DC 20008
 - (b) Edward Kirby, M.D., Washington, DC 20007
 - (c) Carol Kleinman, M.D., Chevy Chase, MD 20815
 - (d) Harold Eist, M.D., Bethesda, MD 20814Respondent shall meet with at least one of the supervising psychiatrists for at least one hour per week. Respondent is not required to attend more than two hours of supervision per week with the supervising psychiatrists.
7. Prior to resuming his practice on October 2, 1991, Respondent shall meet with the selected supervising psychiatrist(s) and he/she shall notify the Board, in writing, that he/she understands the terms of this Order and has reviewed all previous peer review reports and psychiatric evaluations of Respondent.
8. The supervisory psychiatrist(s) will meet with Respondent individually for weekly supervisory sessions for at least one year. The supervisor(s) will determine how much time each week is needed to review Respondent's practice.
9. The supervisory psychiatrist(s) will make quarterly written reports about Respondent's practice of psychiatry to the Board, attention of the Chief Case Manager. The reports are due on January 1, 1992; April 1, 1992; July 1, 1992; and October 1, 1992.
10. In the event that the supervisory psychiatrist(s) believes that Respondent is a danger to his patients or himself, or is not competent to practice psychiatry, or is in violation of this Order, the supervisor will immediately notify the Board.
11. In the quarterly reports due October 1, 1992, the supervisor(s) will discuss whether weekly supervisory sessions should be continued. The Board must ratify the supervisor(s)' recommendations before any change in supervision becomes effective.

Board of Physician Quality Assurance Actions

12. Respondent shall pay all costs associated with the weekly supervisory sessions and the quarterly reports. The supervisory psychiatrist(s) will submit a bill to Respondent on a monthly basis. If Respondent fails to pay the bill in a timely fashion, not to exceed within 60 days, the supervisory psychiatrist(s) will notify the Board. Failure to pay all bills within 60 days shall result in a violation of this Order.
13. Respondent will be subject to an annual peer review of his practice by the SMPS PRC, administrative costs to be paid by the Respondent. The SMPS PRC will submit a report to the Board once each year on the results of the peer review of Respondent's practice, the first report being due on or before October 4, 1992. The Respondent will receive a copy of the report and must follow any recommendations made by SMPS PRC and endorsed by the Board.
14. Respondent shall not engage in the type of conduct that led to the charges brought against him by the Board on April 24, 1991.
15. Respondent shall practice in accordance with the laws governing the practice of medicine in Maryland.
16. Respondent shall be responsible for all costs for the additional training, supervision, and psychiatric therapy that he is to obtain during this probation.

ORDERED that if Respondent violates any of the foregoing conditions of probation, the stay may be lifted and the Board, after notification, a hearing, and a determination of violation, may impose any additional disciplinary sanctions it deems appropriate; and be it further

ORDERED that if Respondent presents a danger to the public health, safety, or welfare, the Board, WITHOUT PRIOR NOTICE AND AN OPPORTUNITY FOR A HEARING, MAY VACATE THE STAY OF SUSPENSION AND REINSTATE THE SUSPENSION, provided that Respondent is given notice of the Board's action and an opportunity for a hearing within thirty days after Respondent requests a hearing; and be it further

ORDERED that on or before 3:00 pm on July 3, 1991, Respondent shall hand-deliver to Margaret T. Anzalone, Deputy Director of the Board, at the Board's office, 4201 Patterson Avenue, Baltimore, Maryland, the following items:

1. his original Maryland license from the Board of Medical Examiners;
2. his most current renewal certificate from the Board;
3. his wallet-size renewal card from the Board;
4. his U.S. Drug Enforcement Administration Registration (DEA) Certificate;
5. his Maryland Controlled Dangerous Substances Registration Certificate;
6. any prescription pads on which his name and DEA number are imprinted;

² These items were delivered prior to the Order being executed as Respondent's good faith gesture that he would execute the Order which was being drafted and revised.

7. all DEA order forms²; and be it further

ORDERED that, three years after the effective date of the Order, that being the date on which the Board signs the Order, Respondent may petition the Board for termination of probation and reinstatement of his license without any conditions or restrictions to the Board. Prior to submitting petition for reinstatement, Respondent must be evaluated by a psychiatrist selected by the Board. Respondent shall bear the burden of proving, to the Board's satisfaction, that he has complied with all the conditions of this Order. NOTHING IN THIS ORDER SHALL BE CONSTRUED AS A PROMISE BY THE BOARD TO REINSTATE RESPONDENT'S LICENSE WITHOUT CONDITIONS; and be further

ORDERED that Respondent will be responsible for all costs incurred under this Consent Order; and be it further

ORDERED that this Consent Order is considered a public document pursuant to *Md. State Gov't Code Ann.* §10-611, *et seq.* (1984).

ISRAEL H. WEINER, M.D., Chairperson
Maryland Board of Physician Quality Assurance

Consent

By signing this Consent, I hereby accept and agree to be bound by the foregoing Consent Order and its conditions and restrictions, consisting of 17 pages.

1. By signing this Consent, I do not admit to the truth of many of the Findings of Fact or agree with the Conclusions of Law. Indeed, I dispute and deny any liability or wrongdoing. However, I submit to the foregoing Order as a resolution of this case.
2. I acknowledge the validity of this Order as if made after a hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by law.
3. I also recognize that I am waiving my right to appeal any adverse ruling of the Board that might have followed any such hearing. By this Consent I waive all such rights.
4. I am not represented by an attorney. When I received the Charges Under the Maryland Medical Practice Act on April 26, 1991, I was advised, in writing, to be represented by an attorney at all stages of this proceeding. I was also advised of my right to have counsel at the Settlement Conference. Considering carefully the advice to have counsel, I chose to exercise my constitutional right to represent myself.
5. I understand that if I fail to comply with any of the conditions of probation enumerated above, I may suffer disciplinary action against my license to practice medicine in the State of Maryland.
6. I understand that if I present danger to the public health, safety, or welfare, the Board may, WITHOUT NOTICE

Board of Physician Quality Assurance Actions

PRIOR TO AN OPPORTUNITY TO BE HEARD, vacate the stay of suspension, reinstate the suspension, and reinstitute formal proceedings against my license to practice medicine in Maryland.

7. I have had an opportunity to review this Order with an attorney. I voluntarily sign this Order understanding its meaning and effect.

OMAR K. OMLAND, M.D.

Physicians' Quality Assurance Board Actions
appear regularly in *MMJ*.

MARYLAND

*The Auxiliary
always welcomes
new members.*

*Auxiliary members support
the physicians and are
recognized for their contri-
butions to health, education,
and the promotion of quality
health care in Maryland.*

For information on becoming a
member, call JoAnn Troisi at
Med Chi's Auxiliary office.

539-0872 (Baltimore area)
1-800-492-1056 (toll free in MD)



Auxiliary

The Auxiliary's Day in Annapolis Wednesday, January 29, 1992

What makes the Auxiliary's Day in Annapolis special? The answer is simple. Individual auxiliary members from all over the state can meet with their own legislators in a warm and friendly atmosphere. It is easy to come, enjoy lunch and just listen to legislative conversations.

This year there will be an informative discussion of some of the hot issues, both pro and con, at the morning meeting. As the State Legislative Chairperson for the Auxiliary, I want to help make everyone feel more comfortable when responding to a legislative alert. There are many times when auxiliary members can really help their local medical societies and Med Chi by writing letters or calling legislators. Participants will get some tips on how to contribute more effectively to this team effort.

Through the years, I have always found the attending legislators to be very friendly in general, and particularly interested in their constituents' concerns. This is an excellent opportunity for auxiliary members to get to know their legislators on a more personal level. Auxilians will walk away with a greater appreciation of the legislative process and the many individuals who influence it.

Anyone wishing to attend, can make reservations by calling Ms. Jo Ann Troisi in the Auxiliary office at Med Chi (410-539-0872 or 1-800-492-1056).

SUE SHERWOOD

Sue Sherwood has been a member of Med Chi's Legislative Committee for five years, a board member of the Maryland Medical Political Action Committee (MMPAC) for three years, and previously served as the editor of *Maryland Medicine*, the MMPAC newsletter. Five years ago, she started a legislative committee in the Auxiliary to the Anne Arundel Medical Society. In addition, she organized a well-attended meeting in November 1991 for Anne Arundel County physicians to learn to use the Med Sig Bulletin Board because of its legislative content. ■



Continuing...

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EPIDEMIOLOGY & DISEASE CONTROL PROGRAM

201 W. Preston Street, Baltimore, Maryland 21201 (410)225-6700

January, 1992

Diphtheria, Tetanus, and Pertussis:

ACIP Recommendations for Vaccine Use and Other Preventive Measures

PREPARATIONS USED FOR VACCINATION

Diphtheria and tetanus toxoids are prepared by formaldehyde treatment of the respective toxins and are standardized for potency according to the regulations of the U.S. Food and Drug Administration.

Pertussis vaccine is a suspension of inactivated *Bordetella pertussis* cells.

The following preparations are currently available in the United States:

1. Diphtheria and Tetanus Toxoids and Pertussis Vaccine Adsorbed (DTP) and Diphtheria and Tetanus Toxoids Adsorbed (DT) (for pediatric use) are for use among infants and children <7 years of age.
2. Tetanus and Diphtheria Toxoids Adsorbed for Adult Use (Td) is for use among persons ≥ 7 years of age.
3. Pertussis Vaccine Adsorbed (P), Tetanus Toxoid (fluid), Tetanus Toxoid Adsorbed (T), and Diphtheria Toxoid Adsorbed (D) (for pediatric use), are single-antigen products for use in special instances when combined antigen preparations are not indicated.

Work is in progress to study the effectiveness of improved acellular pertussis vaccines that have reduced adverse reaction rates. Currently, several candidate vaccines containing at least one of the bacterial components thought to provide

protection are undergoing clinical trials. In published studies, some of these vaccines are less prone to cause common adverse reactions than the current whole-cell preparations, and they are immunogenic. Whether their clinical efficacy among infants is equivalent to that of the whole-cell preparations remains to be established.

VACCINE USAGE

The standard, single-dose volume of each of DTP, DT, Td, single-antigen adsorbed preparations of pertussis vaccine, tetanus toxoid, and diphtheria toxoid, and of the fluid tetanus toxoid is 0.5 mL. Adsorbed preparations should be administered intramuscularly (IM).

TABLE 1. Routine diphtheria, tetanus, and pertussis vaccination schedule summary for children <7 years of age—United States, 1991

Dose	Customary age	Age/interval	Product
Primary 1	2 months	6 week old or older	DTP [†]
Primary 2	4 months	4-8 weeks after first dose*	DTP [†]
Primary 3	6 months	4-8 weeks after second dose*	DTP [†]
Primary 4	15 months	6-12 months after third dose*	DTP [†]
Booster	4-6 years old, before entering kindergarten or elementary school (not necessary if fourth primary vaccinating dose administered after fourth birthday)		DTP [†]
Additional boosters		Every 10 years after last dose	Td

*Prolonging the interval does not require restarting series.

[†]Use DT if pertussis vaccine is contraindicated. If the child is ≥ 1 year of age at the time that primary dose three is due, a third dose 6-12 months after the second completes primary vaccination with DT.

TABLE 2. Routine diphtheria, tetanus, and pertussis vaccination schedule summary for persons ≥ 7 years of age—United States, 1991

Dose	Age/interval	Product
Primary 1	First dose	Td
Primary 2	4-8 weeks after first dose*	Td
Primary 3	6-12 months after second dose*	Td
Booster	Every 10 years after last dose	Td

*Prolonging the interval does not require restarting series.

PRIMARY VACCINATION AND BOOSTERS

Vaccination schedules for children <7 and those ≥ 7 and adults are shown in Tables 1 and 2.

SPECIAL CONSIDERATIONS

For children < 7 years of age with a contraindication to pertussis vaccine (see Precautions and Contraindications), DT should be used instead of DTP. To ensure that there will be no interference with the response to DT antigens from maternal antibodies, previously unvaccinated children who receive their first DT dose when <1 year of age should receive a total of four doses of DT as the primary series, the first three doses at 4 to 8 week intervals and the fourth dose 6-12 months later (similar to the recommended DTP schedule) (Table 1). If additional doses of pertussis vaccine become contraindicated after a DTP series is begun in the first year of life, DT should be substituted for each of the remaining scheduled DTP doses.

Unvaccinated children ≥ 1 year of age for whom pertussis vaccine is contraindicated should receive two doses of DT 4-8 weeks apart, followed by a third dose 6-12 months later to complete the primary series. Children who have already received one or two doses of DT or DTP after their first birthday and for whom further pertussis vaccine is contraindicated should receive a total of three doses of a preparation containing diphtheria and tetanus toxoids appropriate for age, with the third dose administered 6-12 months after the second dose. Children who complete a primary series of DT before their fourth birthday should receive a fifth dose of DT before entering kindergarten or elementary school. This dose is not necessary if the fourth dose of the primary series was given after the fourth birthday.

PERSONS WHO HAVE RECOVERED FROM TETANUS OR DIPHTHERIA

Tetanus or diphtheria infection may not confer immunity; therefore, active vaccination should be initiated at the time of recovery from the illness, and arrangements made to ensure that all doses of a primary series are administered on schedule.

CHILDREN WHO HAVE RECOVERED FROM PERTUSSIS

Children who have recovered from satisfactorily documented pertussis do not need pertussis vaccine. Satisfactory documentation includes recovery of *B. pertussis* on culture or typical symptoms and clinical course when epidemiologically linked to a culture-proven case, as may occur during outbreaks. When such confirmation of the diagnosis is lacking, DTP vaccination should be completed, because a presumed pertussis syndrome may have been caused by other *Bordetella* species, *Chlamydia*, or certain viruses.

ADULT VACCINATION WITH Td

Adults with uncertain histories of a complete primary vaccination series should receive a primary series using the combined Td toxoid (Table 2). To ensure continued protection, booster doses of Td should be given every 10 years.

USE OF SINGLE-ANTIGEN PREPARATIONS

Available data do not indicate substantially more adverse reactions following receipt of Td than following receipt of single-antigen, adsorbed tetanus toxoid. Furthermore, adults may be even less likely to have adequate levels of diphtheria antitoxin than of tetanus antitoxin. The routine use of Td in all medical settings, including office practices, clinics, and emergency rooms, for all persons ≥ 7 years of age who need primary vaccination or booster doses will improve levels of protection against both tetanus and diphtheria, especially among adults.

SIDE EFFECTS AND ADVERSE REACTIONS FOLLOWING DTP VACCINATION

Local reactions (generally erythema and induration with or without tenderness) are common after the administration of vaccines containing diphtheria, tetanus, or pertussis antigens. Occasionally, a nodule may be palpable at the injection site of adsorbed products for several weeks. Sterile abscesses at the injection site have been reported rarely (6-10/million doses of DTP). Mild systemic reactions such as fever, drowsiness, fretfulness, and anorexia occur frequently. These reactions are substantially more common following the administration of DTP than of DT, but they are self-limited and can be safely managed with symptomatic treatment.

Acetaminophen is frequently given by physicians to lessen fever and irritability associated with DTP vaccination, and it may be useful in preventing seizures among febrile-convulsion-prone children. However, fever that does not begin until ≥ 24 hours after vaccination or persists for more than 24 hours after vaccination should not be assumed to be due to DTP vaccination. These new or persistent fevers should be evaluated for other causes so that treatment is not delayed for serious conditions such as otitis media or meningitis. Moderate-to-severe systemic events, include high fever (i.e., temperature of $\geq 40.5^\circ \text{C}$ (105°F); persistent, inconsolable crying lasting ≥ 3 hours; collapse (hypotonic-hyporesponsive episode); or short-lived convulsions (usually febrile). These events occur infrequently. These events appear to be without sequelae. Other more severe neurologic events, such as a prolonged convulsion or encephalopathy, although rare, have been reported in temporal association with DTP administration.

The National Childhood Encephalopathy Study (NCES) was the basis of prior Immunization Practices Advisory Committee (ACIP) statements suggesting that on rare occasions DTP vaccine could cause brain damage. However, on the basis of a more detailed

review of the NCES data as well as data from other studies, the ACIP has revised its earlier view and now concludes:

1. Although DTP may rarely produce symptoms that some have classified as acute encephalopathy, a causal relation between DTP vaccine and permanent brain damage has not been demonstrated. If the vaccine ever causes brain damage, the occurrence of such an event must be exceedingly rare. A similar conclusion has been reached by the Committee on Infectious Diseases of the American Academy of Pediatrics, the Child Neurology Society, the Canadian National Advisory Committee on Immunization, the British Joint Committee on Vaccination and Immunization, the British Pediatric Association, and the Institute of Medicine.
2. The risk estimate from the NCES study of 1:330,000 for brain damage should no longer be considered valid on the basis of continuing analyses of the NCES and other studies.

Recent data suggest that infants and young children who have ever had convulsions (febrile or afebrile) or who have immediate family members with such histories are more likely to have seizures following DTP vaccination than those without such histories. For those with a family history of seizures, the increased risks of seizures occurring within 3 days of receipt of DTP or 4-28 days following receipt of DTP are identical, suggesting that these histories are non-specific risk factors and are unrelated to DTP vaccination.

Rarely, immediate anaphylactic reactions (i.e., swelling of the mouth, breathing difficulty, hypotension, or shock) have been reported after receipt of preparations containing diphtheria, tetanus, and/or pertussis antigens. However, no deaths caused by anaphylaxis following DTP vaccination have been reported to CDC since the inception of vaccine-adverse-events reporting in 1978, a period during which more than 80 million doses of publicly purchased DTP vaccine were administered.

REPORTING OF ADVERSE EVENTS

The U. S. Department of Health and Human Services has established a new Vaccine Adverse Event Reporting System (VAERS) to accept all reports of suspected adverse events after the administration of any vaccine, including but not limited to the reporting of events required by the National Childhood Vaccine Injury Act of 1986. The telephone number to call for answers to questions and to obtain VAERS forms is 1-800-822-7967, or in Maryland 410-225-6679. *Vaccine adverse events are reportable to your local health department in Maryland.*

REDUCED DOSAGE SCHEDULES OR MULTIPLE SMALL DOSES OF DTP

The ACIP recommends giving only full doses (0.5mL) of DTP vaccine; if a specific contraindication to DTP exists, the vaccine should not be given.

Concern about adverse events following pertussis vaccine has led some practitioners to reduce the volume of DTP vaccine administered to <0.5mL/dose in an attempt to reduce side effects. No evidence exists to show that this decreases the frequency of uncommon severe adverse events, such as seizures and hypotonic-hyporesponsive episodes.

SIMULTANEOUS ADMINISTRATION OF VACCINES

The simultaneous administration of DTP, oral poliovirus vaccine (OPV), and measles-mumps-rubella vaccine (MMR) has resulted in seroconversion rates and rates of side effects similar to those observed when the vaccines are administered separately. Simultaneous vaccination with DTP, MMR, OPV, or inactivated poliovirus vaccine (IPV), and *Haemophilus b* conjugate vaccine (HbCV) is also acceptable. The ACIP recommends the simultaneous administration of all vaccines appropriate to the age and previous vaccination status of the recipient, including the special circumstance of simultaneous administration of DTP, OPV, HbCV, and MMR at 15 months of age.

PRECAUTIONS AND CONTRAINDICATIONS

General Considerations

The decision to administer or delay DTP vaccination because of a current or recent febrile illness depends largely on the severity of the symptoms and their etiology. Although a moderate or severe febrile illness is sufficient reason to postpone vaccination, minor illnesses such as mild upper-respiratory infections with or without low-grade fever are not contraindications.

Routine physical examinations or temperature measurements are not prerequisites for vaccinating infants and children who appear to be in good health. Appropriate immunization practice includes asking the parent or guardian if the child is ill, postponing DTP vaccination for those with moderate or severe acute ill-

TABLE 3. Contraindications and precautions to further DTP vaccination

Contraindications

- An immediate anaphylactic reaction.
- Encephalopathy occurring within 7 days following DTP vaccination.

Precautions

- Temperature of ≥ 40.5 C (105 F) within 48 hours not due to another identifiable cause.
- Collapse or shock-like state (hypotonic-hyporesponsive episode) within 48 hours.
- Persistent, inconsolable crying lasting ≥ 3 hours, occurring within 48 hours.
- Convulsions with or without fever occurring within 3 days.

nesses, and vaccinating those without contraindications or precautionary circumstances.

A history of prematurity generally is not a reason to defer vaccination.

Special Considerations for Preparations Containing Pertussis Vaccine

Contraindications

If any of the events listed in Table 3 occur in temporal relationship to the administration of DTP, further vaccination with DTP is contraindicated (see Table 3).

Misconceptions Concerning Contraindications to DTP

Some health-care providers *inappropriately* consider certain conditions or circumstances as contraindications to DTP vaccination. These include the following:

1. Soreness, redness, or swelling at the DTP vaccination site or temperature of $<40.5^{\circ}\text{C}(105^{\circ}\text{F})$.
2. Mild, acute illness with low-grade fever or mild diarrheal illness affecting an otherwise healthy child.
3. Current antimicrobial therapy or the convalescent phase of an acute illness.
4. Recent exposure to an infectious disease.
5. Prematurity. The appropriate age for initiating vaccination among the prematurely born infant is the usual chronological age from birth. Full doses (0.5 mL) of vaccine should be used.
6. History of allergies or relatives with allergies.
7. Family history of convulsions.
8. Family history of SIDS.
9. Family history of an adverse event following DTP vaccination.

TETANUS PROPHYLAXIS IN WOUND MANAGEMENT

Chemoprophylaxis against tetanus is neither practical nor useful in managing wounds. Wound cleaning, debridement when indicated, and proper immunization

are important. The need for tetanus toxoid (active immunization), with or without TIG (passive immunization), depends on both the condition of the wound and the patient's vaccination history (Table 4;). If a contraindication to using tetanus toxoid-containing preparations exists for a person who has not completed a primary series of tetanus toxoid immunization and that person has a wound that is neither clean nor minor, *only* passive immunization should be given using tetanus immune globulin (TIG). Rarely has tetanus occurred among persons with documentation of having received a primary series of toxoid injections.

PROPHYLAXIS FOR CONTACTS OF PERTUSSIS PATIENTS

Spread of pertussis can be limited by decreasing the infectivity of the patient and by protecting close contacts. To reduce infectivity as quickly as possible, a course of oral erythromycin (children: 40 mg/kg/day; adults: 1 g/day) or trimethoprim-sulfamethoxazole (children: trimethoprim 8 mg/kg/day, sulfamethoxazole 40 mg/kg/day; adults: trimethoprim 320 mg/day, sulfamethoxazole 1,600 mg/day) is recommended for patients with clinical pertussis. Antimicrobial therapy should be continued for 14 days to minimize any chance of treatment failure.

Erythromycin or trimethoprim-sulfamethoxazole prophylaxis should be administered for 14 days to all household and other close contacts of persons with pertussis, regardless of age and vaccination status. Although data from controlled clinical trials are lacking, prophylaxis of all household members and other close contacts may prevent or minimize transmission. All close contacts <7 years of age who have not completed the four-dose primary series should complete the series with the minimal intervals (Table 1). Those who have completed a primary series but have not received a dose of DTP vaccine within 3 years of exposure should be given a booster dose.

TABLE 4. Summary guide to tetanus prophylaxis in routine wound management, 1991

History of adsorbed tetanus toxoid (doses)	Clean, minor wounds		All other wounds*	
	Td([†])	TIG	Td([†])	TIG
Unknown or <3	Yes	No	Yes	Yes
≥ 3 ([§])	No([†])	No	No(^{**})	No

*Such as, but not limited to, wounds contaminated with dirt, feces, soil, and saliva; puncture wounds; avulsions; and wounds resulting from missiles, crushing, burns and frostbite.

[†]For children <7 years old; DTP (DT, if pertussis vaccine is contraindicated) is preferred to tetanus toxoid alone. For persons ≥ 7 years of age, Td is preferred to tetanus toxoid alone.

[§]If only three doses of *fluid* toxoid have been received, then a fourth dose of toxoid, preferably an adsorbed toxoid, should be given.

[†]Yes, if >10 years since last dose.

^{**}Yes, if >5 years since last dose. (More frequent boosters are not needed and can accentuate side effects.)

American Medical Association

Physicians dedicated to the health of America



For Your Benefit

Materials included are excerpted from *Member Matters*, a monthly publication sent to all members of the American Medical Association. *For Your Benefit* is provided by the American Medical Association.

AMA Helps Our Patients Lead Healthier Lives

Providing information to help your patients has always been an integral part of the American Medical Association's mission. What distinguishes today's patient activities from past efforts is the AMA's direct and individual approach ... echoing the trust and support patients experience from their own physicians.

Major activities include the Consumer Book Program, a weekly television show on health, national health campaigns and a test for a consumer health magazine.

Highlights of these projects are:

- the *AMA Handbook of First-Aid and Emergency Care*, was ranked fifth on the Book-of-the-Month Club's best-seller list,

- "Living Well America!" broadcast Sunday mornings and hosted by NBC's "Today Show" Dr. Art Ulene, is a fast-paced, entertaining program focusing on everyday health problems,

- "Campaign Against Cholesterol," provides information on the dangers of cholesterol through a series on NBC's the "Today Show," and

- the "Women's Health Campaign" began in January with activities that include TV reports, disseminating health materials and community awareness seminars.

What next? Future projects include a children's health campaign and a smoking cessation program for 1992.

AMA Works to Retain and Increase Loan Deferment

The AMA is working with specialty societies, residents, medical students and the Congress to:

- retain and increase the number of years available for deferment of loans for resident physicians to at least 3 years, and
- restore the maximum length of time for forbearance to 10 years regardless of the amount of resident's income.

Coalition letters are to be sent to the

Senate and the House requesting that both the House's H.R. 3553 bill and the Senate's S. 1150 bill contain provisions for at least a 3 year loan deferment, with no limitations and with no restrictions on forbearance.

Elimination of deferments for several different employment groups was a move to generate budget savings to fund other education programs.

AMA Confronts Epidemic of Family Violence

More than 2 million cases of child abuse and neglect are reported each year. Each year, as much as 3% of the elderly population is abused. According to a recent article in the *Journal of the American Medical Association*, domestic violence is the single largest cause of injury to women in the U.S.: more common than car accidents, muggings and rape combined. Other forms of family violence, including sexual abuse and mistreatment of the elderly, have barely been addressed.

Conservative estimates put the annual medical costs of family violence at \$44 million — the equivalent of almost 100,000 days of hospitalizations; almost 30,000 emergency department visits; and almost 40,000 visits to a physician each year. Virtually all estimates indicate that the problem continues to grow.

The AMA has declared a new initiative against family violence by launching its national Campaign Against Family Violence to provide physicians with specific, practical education on the diagnosis of violence-related problems, and the counseling and treatment of these victims.

Physicians are the key to ending the cycle of violence. They are the people in a position to identify victims and potential victims of abuse, to make sure victims receive treatment, and most important, make sure the violence is not repeated.

Robert E. McAfee, MD, the AMA's associate vice chairman, said 570,000 physicians will receive letters from the AMA urging them to join the Physicians' Campaign Against Family Violence. "We want an expression of support for the program from every physician regardless of specialty," he said. The campaign will show us how to learn from each other, to start programs in our communities and to lobby for state legislation to finance agencies which will support our efforts. Responses will impact the AMA's guidelines on family violence due to be released in January, 1992.

AMA guidelines, developed for primary care physicians, will help physicians recognize abuse from a list of warning signs, question patients in a caring way and refer them to social service agencies or shelters for legal aid or counseling support.

With the help of the AMA Auxiliary, the AMA plans to develop comprehensive directories of local agencies to which physicians can refer these victims.

Currently, abuse victims can get help through the 24-hour National Domestic Violence Hotline at 1-800-333-7233, or by writing the Council on Battered Women, P.O. Box 54383, Atlanta, GA 30308.

The AMA, involved in this issue since 1982, has gone beyond recommending national policy. Recent activities include national conferences on child abuse and neglect, and on the prevention of family violence. AMA research and reports examine child, sexual and elder abuse, missing and exploited children and child pornography. Upcoming anti-violence AMA projects include:

- the AMA national family violence prevention resource center assembling research and resources for health care providers,
- surveying of physicians and public attitudes and knowledge about family violence to establish a baseline against which to measure the success of AMA anti-violence efforts,
- promoting research on violence as a public health problem, and
- influencing public policy regarding violence treatment and prevention.

AMA member Kevin Fullin, MD, of Kenosha, Wisconsin, featured in our national promotions and who established the first Domestic Violence Advocate Program in his state, says: "Being a patient advocate is what being a physician is all about."



Five



Issues



In



American



Health

PHYSICIAN OF THE DAY

Please indicate your willingness to serve as physician of the day
in the First Aid Room in Annapolls.

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General Assembly Dates: January 8 - April 6, 1992

DATES I CAN SERVE (Please Circle): Give First and Second Choice

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Second Choice _____

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13	14	15	16	17		
20	21	22	23	24		
27	28	29	30	31		

February						
M	T	W	T	F		
	3	4	5	6	7	
10	11	12	13	14		
17	18	19	20	21		
24	25	26	27	28		

March						
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April						
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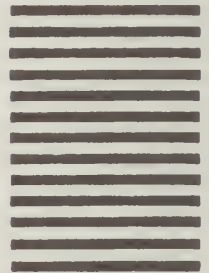
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We Need A Doctor In The House

When the Maryland General Assembly convenes in Annapolis for its 1992 session, the Medical and Chirurgical Faculty will be there. Since 1964, Med Chi has staffed the first aid facility operated during the 90-day legislative session. Come join us at the state capitol building, see the laws being made first hand. One doctor a day is all that is needed to care for the public, the legislators, and their staffs. Take advantage of the opportunity to donate something priceless, your time.

Please detach the postcard located at the top of this page, fill it out and mail it. A confirmation card will be sent to you explaining the details. You will be carrying on a tradition established by the medical community for the people of Maryland.

Doctor of the Day 1992



Note: All Monday dates are evening sessions, beginning at 4:00 p.m. and ending at 9:00 p.m. For more information, call Bernadette LaRue at Med Chi's Legal Department, 301-539-0872 or call toll free in Md. at 1-800-492-1056.

Your time can make a difference.



Performing Arts Medicine:

ISSUES IN
DIAGNOSIS AND MANAGEMENT

Are you a primary care physician who sees a few performers? Or do you specialize in the care of musicians and dancers? Maybe you are an allied health care professional or performer yourself who would benefit from our sessions. If you are, plan on attending the Medical and Chirurgical Faculty's conference on Friday and Saturday, January 24 and 25, 1992 at the Med Chi Faculty Building 1211 Cathedral Street Baltimore, Md.

Speakers will include Dr. Hunter Fry, an Australian expert in overuse injuries. Dr. Fry has shown continued interest in the growth of arts medicine in Maryland.

Other speakers include:

David Sternbach, L. C. S. W.; Richard Norris, M. D.; and committee members Emidio Bianco, M. D.; Sandra Bishop; Scott Brown, M. D.; Ruth Drucker; David Fetter; Norman Rosen, M. D.; Leo Rozmaryn, M. D.; and Charles Silberstein, M. D.



Medical
and Chirurgical Faculty
of Maryland

Medical and Chirurgical Faculty's Committee on Medicine and the Performing Arts Conference

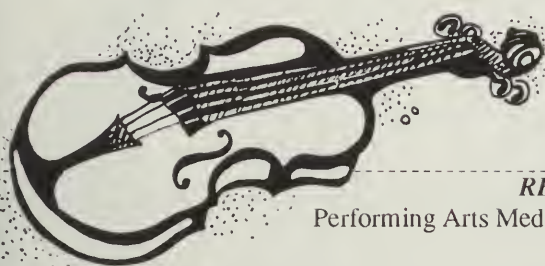
Friday & Saturday January 24 & 25, 1992

Med Chi Faculty Building
1211 Cathedral Street Baltimore, Md



Topics to be covered include:

- Soft tissue and overuse injuries of instrumentalists
- Epidemiology of performance related problems
- Approach to the performing artist as a patient
- Medicolegal issues in the performing arts
- Medical problems in the training of the young dancer
- Prevention and treatment of performance anxiety
- Orthotics and instrument adaptations
- Myofascial pain syndromes in the musician



There will be a panel of professional musicians covering the fields of classical, jazz, and rock music who will discuss and respond to questions regarding the musician's role in society and special career demands in their particular area. Three concurrent roundtables covering vocal medicine, dance medicine, and instrumentalists' problems will include case presentations by local experts. Steve Turley, a guitarist from Peabody Conservatory, will give a short lecture-concert.

The conference will run from approximately 12:30 to 5:00 p.m. on Friday and 8:30 a.m. to 5:00 p.m. Saturday.

The Medical and Chirurgical Faculty of Maryland is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

REGISTRATION FORM

Performing Arts Medicine: Issues in Diagnosis and Management
January 24-25, 1992

Physicians - \$50.00

Tuition assistance available.

Allied Health - \$35.00

Students and Musicians - \$15.00

Name: _____

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First

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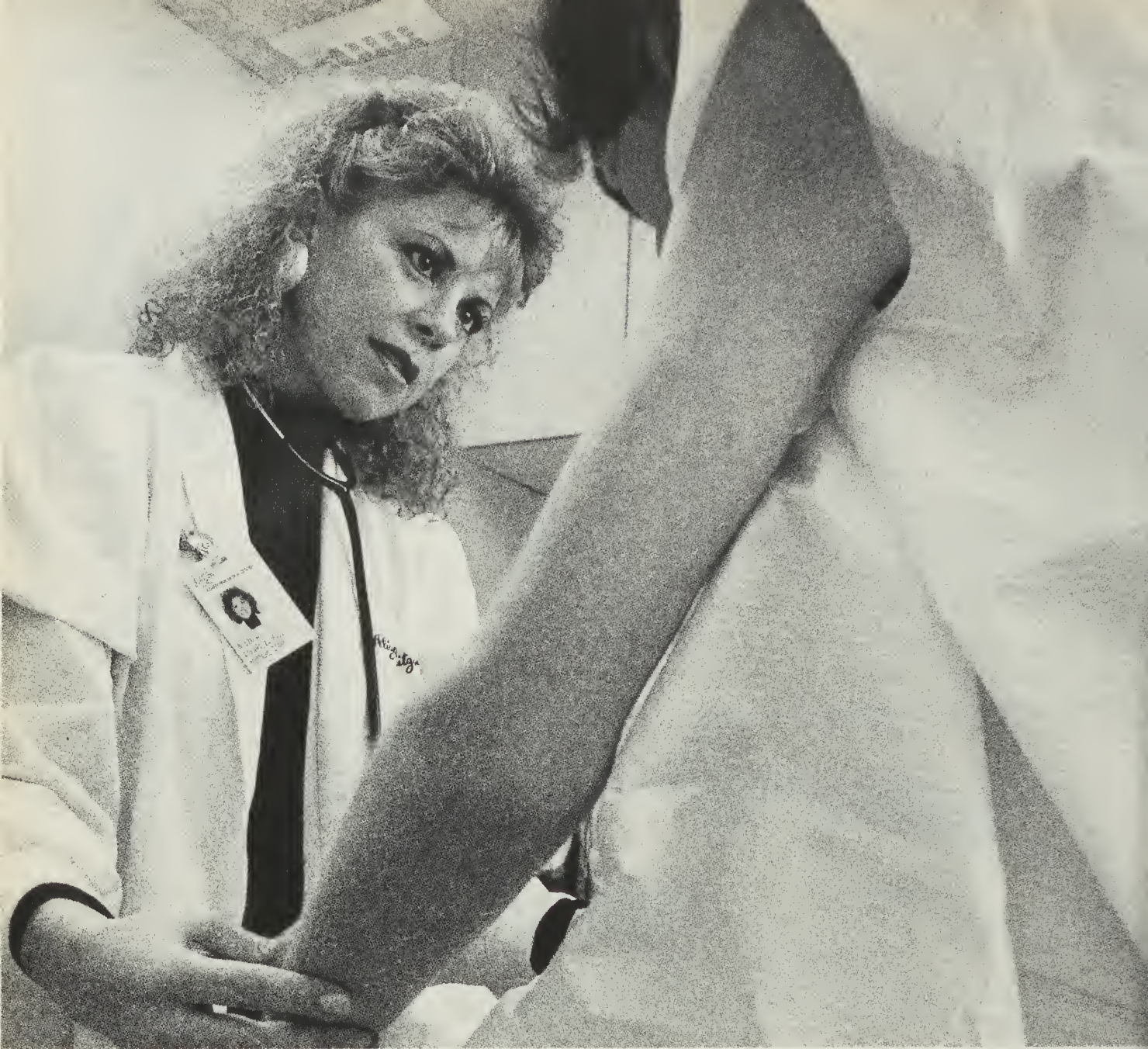
Return this Registration Form and your payment to:
Med Chi 1211 Cathedral Street/Baltimore, MD 21201-5585

For additional information...

Contact Susan Harman at (301) 539-0872
Monday through Friday, 9:00 a.m. to 5:00 p.m.

Toll free in Maryland 1-800-492-1056
FAX 301-547-0915





"I have never gotten used to people dying. And I don't want to get used to it."

Dr. Aliza Lifshitz, Internist, Los Angeles, California, Member, American Medical Association

Patients come to physicians for many reasons. Beyond relief from pain, they seek compassion, empathy and support. AIDS patients receive all of these and more from Dr. Aliza Lifshitz.

Born and raised in Mexico and educated at one of Mexico City's finest medical schools, Dr. Lifshitz now serves the Hispanic community in Southern California. Over a third of her patients have tested HIV positive. Most live below the poverty level. Many are illegal aliens.

"I never forget what it means to be a doctor, and what it means is embodied in the Principles of Medical

Ethics of the American Medical Association (AMA)," states Dr. Lifshitz.

You are invited to join Dr. Lifshitz and to join with her in her efforts to bring quality health care to those in need. Become a member of the American Medical Association today.

Members of the AMA are encouraged to join their state, county and specialty societies.

American Medical Association

Physicians dedicated to the health of America



The Johns Hopkins Medical Institutions

All courses at the Turner Auditorium unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Education, 720 Rutland Ave., Baltimore, MD 21205 (410-955-2959).

- | | |
|--|----------------------------------|
| Recent advances in the management of age-related macular degeneration: Guidelines from recent clinical trials. 8 Cat 1 AMA/PRA credits. Fee: \$200 physicians; \$100 residents, fellows and allied health professionals. | Jan. 5 |
| Advances in cardiovascular diagnosis and treatment: 1992. 15.5 Cat 1 AMA/PRA credits. Fee: \$150 physicians; \$80 residents. | Jan. 9-10 |
| Frontiers in research and clinical management of asthma and allergy, at The Johns Hopkins Asthma and Allergy Center, Baltimore, MD. 15 Cat 1 AMA/PRA credits. Fee: \$350 physicians; \$225 residents, fellows and allied health professionals. | Jan. 24-26 |
| Endoscopic sinus surgery: Laboratory and lecture series. Cat 1 AMA/PRA credit available. Fee: \$1,250 hands-on laboratory course; \$295 lecture series only. | Jan. 30 - Feb. 1 |
| PET and SPECT imaging of living brain chemistry in health and disease. 19 Cat 1 AMA/PRA credits. Fee: \$495 physicians; \$395 residents. Info: Julia W. Buchanan, 410-955-8582. | Mar. 11-13 |
| 33rd annual postgraduate institute for pathologists in clinical cytopathology for board certified (or qualified) pathologists as a subspecialty residency. 140 Cat 1 AMA/PRA credits for two courses, both of which must be taken. Preregistration must be completed by March 15, 1992. | Feb. - Apr. |
| Home study, course A. Personal reading and microscopic study in preparation for course B.
In-residence, course B. Concentrated lecture series with intensive laboratory studies. | Feb. - Apr.
Apr. 6-17 |

Continuously throughout the year

- Visiting preceptorship in pediatric critical care medicine.** Ongoing 5-day preceptorship by appointment. 40 Cat 1 AMA/PRA credits. Fee: \$600.
- Ophthalmic electrophysiology technician training course.** Ongoing one-week course by appointment. The Wilmer Eye Institute, Baltimore, MD.
- Ophthalmology grand rounds.** Audiovisual continuing education series of case discussions for clinicians; 3-8 topics per conference. Thursdays, 7:30-9:00 AM. 2 Cat 1 AMA/PRA credits per session. Info: 410-955-5700.
- Neuro-ophthalmology conference.** Held twice per month. Info: 410-955-5700.
- Cornea conference.** Held monthly. Info: 410-955-5700.
- The department of radiology and radiological sciences** offers several courses in abdominal and obstetrical ultrasound. Info: P. Williams 410-955-3169.
- Visiting physicians.** Offered throughout the year for experience in the lab and participation in read-in sessions; by appointment only. 40 Cat 1 AMA/PRA credits. Fee: \$500.
- Johns Hopkins medical grand rounds.** Accredited audiovisual continuing education series of case discussions for clinicians; 30 topics per year in five bimonthly programs. Individual and group subscriptions. 40 Cat 1 AMA/PRA credits. Info: 410-955-3988.
- Microsurgery training at The Johns Hopkins Hospital.** One-week program offered continuously throughout the year. 40 Cat 1 AMA/PRA credits. Info: P. Williams 410-955-3169.

University of Maryland

CME courses: For each course, additional information may be obtained by contacting the Program of Continuing Education, University of Maryland School of Medicine, Room 14-011, BRB, 655 W. Baltimore St., Baltimore, MD 21201 (410-328-3956) or by calling the phone number listed after a specific program. FAX 410-328-3103.

- Subspecialty care in general pediatric practice**, at the University Club, UMAB campus, Baltimore, MD. 1 Cat 1 AMA/PRA credit. Fee: \$50. Info: Richard Ringel, M.D., 410-328-6666. **Jan. 7, Mar. 4 & May 5**
- Laparoscopic surgery: The team approach.** 14 Cat 1 AMA/PRA credits. Fee: \$2,500. Info: Pat Rahmiow, 410-321-5481. **Jan. 24-25 & Mar. 27-28**
- R. Adams Cowley 14th national trauma symposium**, at the Hyatt Regency, Baltimore, MD. Info: Kimberly C.A. Unitas, 410-328-2399. **Mar. 6-8**
- Current cancer therapy symposium.** Info: Sharon Stenhouse, 410-328-3956. **Apr. 3**
- 2nd annual symposium on infectious disease in everyday medicine.** 12 Cat 1 AMA/PRA credits. Fee: \$175. Info: Eunice Katz, 410-328-3956/7560. **Apr. 23-24**

Continuously throughout the year

Visiting professor program — A new 1992 directory of speakers and their topics is available to area hospitals and other health care organizations. NO administrative fees are charged for this service. Info: 410-328-3956.

Departmental rounds and conferences — Weekly, hands-on and lecture presentations hosted by the University's clinical departments. Hour-for-hour Cat 1 AMA/PRA credits available. Brochure available.

Miscellaneous meetings

- Performing arts medicine: Issues in diagnosis and management**, sponsored by Med Chi's Committee on Medicine and the Performing Arts, at the Faculty Building, Baltimore, MD. 9 Cat 1 AMA/PRA credits. Fee: \$50 physicians; \$35 allied health professionals; \$15 musicians and students. Info: Susan Harman, 410-539-0872 or 1-800-492-1056. **Jan. 24-25**
- How to market your medical practice without advertising**, at Howard Community College, Columbia, MD. Fee: \$60. Info: Office of Continuing Education, 410-964-4944 or Sheryl Kurland, 410-750-6990. **Feb. 8**
- Aging: The quality of life**, sponsored by the Christopher Columbus Medical Sciences Committee of the National Institutes of Health at the Omni Sheraton Hotel, Washington, D.C. 21.5 Cat 1 AMA/PRA credits. Fee: \$200; \$250 on site. Info: Suzanne Kuntz, 202-639-4524. **Feb. 10-12**
- Meeting of the Mid-Atlantic Regional Chapter of the American College of Sports Medicine**, at Western Maryland College, Westminster, MD. Info: Dr. Samuel Case, 301-857-2570. **Feb. 21-22**
- Perspectives in orthopaedics and sports medicine**, sponsored by the Maryland Academy of Family Physicians at Wisp Resort, Deep Creek Lake, McHenry, MD. 5 Cat 1 AMA/PRA credits; 5 AAFP prescribed hours. Fee: \$55 MAFP members; \$80 nonmembers; \$35 paramedicals; free for residents, medical students, and MAFP retired and life members. Info: John B. Umhau, Jr., M.D., 410-747-1980. **Mar. 7**
- 32nd annual scientific session and annual meeting of the Maryland Thoracic Society**, at the Baltimore Marriott-Inner Harbor Hotel, Baltimore, MD. 14 Cat 1 AMA/PRA credits. Info: Valerie D. Craig, 410-560-2120. **Mar. 7-8**
- Mini-invasion and megatreatments: Med Chi's 194th annual meeting**, at the Omni Inner Harbor Hotel, Baltimore, MD. Info: Betsy Newman, 410-539-0872 or 1-800-492-1056. **Apr. 30 - May 2**

- The annual meeting of the Virginia Society of Otolaryngology — Head and Neck Surgery**, at the Boar's Head Inn, Charlottesville, VA. Info: Donna Scott, 804-353-2721. **May 1-2**
- Trauma is no accident: 92/societal violence — A national epidemic**, sponsored by the American Trauma Society at the McLean Hilton, McLean, VA. Info: 800-556-7890. **May 6-8**
- 44th annual meeting and scientific session of the Maryland Academy of Family Physicians**, at the Sheraton Ocean City Resort and Conference Center, Ocean City, MD. 30.75 Cat 1 AMA/PRA credits; 30.75 AAFP prescribed hours. Fee: \$195 MAFP members; \$225 nonmembers; \$110 paramedicals; free for residents, medical students, and MAFP retired and life members. Info: Francis C. Bruno, M.D., 410-747-1980. **May 13-17**
- Virginia Society of Ophthalmology annual meeting**, at the Marriott, Richmond, VA. Info: Donna Scott, 804-353-2721. **May 15-16**

Shady Grove Adventist Hospital

9901 Medical Center Drive, Rockville, MD. Info: 301-279-6115.

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| Total medical management of the diabetic foot. | Jan. 9 |
| Diabetic update for the 1990s. | Jan. 16 |
| Transesophageal echocardiography. | Jan. 23 |
| Laparoscopic-assisted vaginal hysterectomy. | Jan. 30 |
| Overview of the new angiography suite at SGAH. | Feb. 6 |
| Cardiac transplantation: Current state of the art. | Feb 20 |
| Sleep disorders. | Mar. 5 |
| New aspects of allergic rhinitis. | Mar. 12 |
| Advances and controversies in breast reconstruction. | Mar. 19 |
| Pediatric surgery. | Mar. 26 |
| Advances in management of testicular tumors. | Apr. 2 |
| Risk management. | Apr. 9 |

AMA'S PHYSICIAN'S RECOGNITION AWARD PHYSICIAN'S RECOGNITION AW



PHYSICIAN'S RECOGNITION AWARD

During October 1991, the physicians listed below received the American Medical Association's (AMA's) Physician's Recognition Award. Established in 1968, the Award's purpose is to encourage physician participation in continuing medical education and to recognize those physicians who have voluntarily completed programs of continuing medical education.

Beninger, Paul Richard
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Eshal, Mehjabeen
Guedenet, Robert Jean S.
Hall, James Lyman
Hardware, Leslie W.
Jafari, Robin
Jaffe, Mark Jonathan

Kalish, Murray Alvin
Kanner, Martin Zelig
Krulvitz, Keaciel K.
Lang, Richard Collison
Orleans, Ronald Julian
Prabhakar, M.L.
Ray, Uthman
Rieckert, Peter Walter

Roane, Donald Cornelius
Rossi, James Anthony
Semmes, Luette Spitzer
Silver, Joy Ellen
Tadalan, Vilma F.
Tucker, Steven Willie
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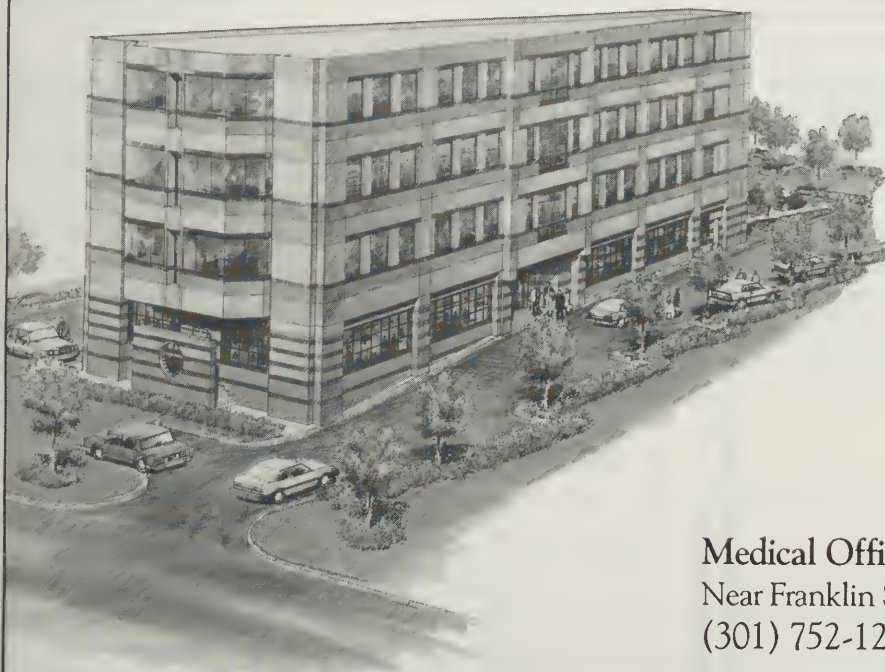
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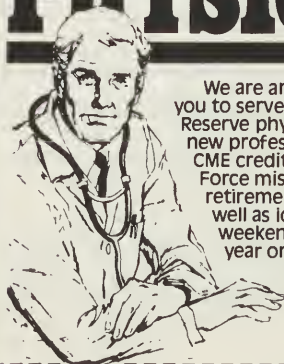
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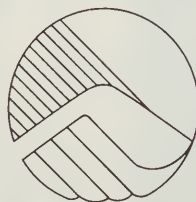
Med Chi's Physician Rehabilitation Committee deals with the substance abuse and mental health problems of Maryland physicians, with a confidential and nondisciplinary focus...Addiction, Marital /Family Conflicts, Psychiatric Illness, Organic Impairment, Physical Handicap...If these problems exist, we can help find the solution. Call us.

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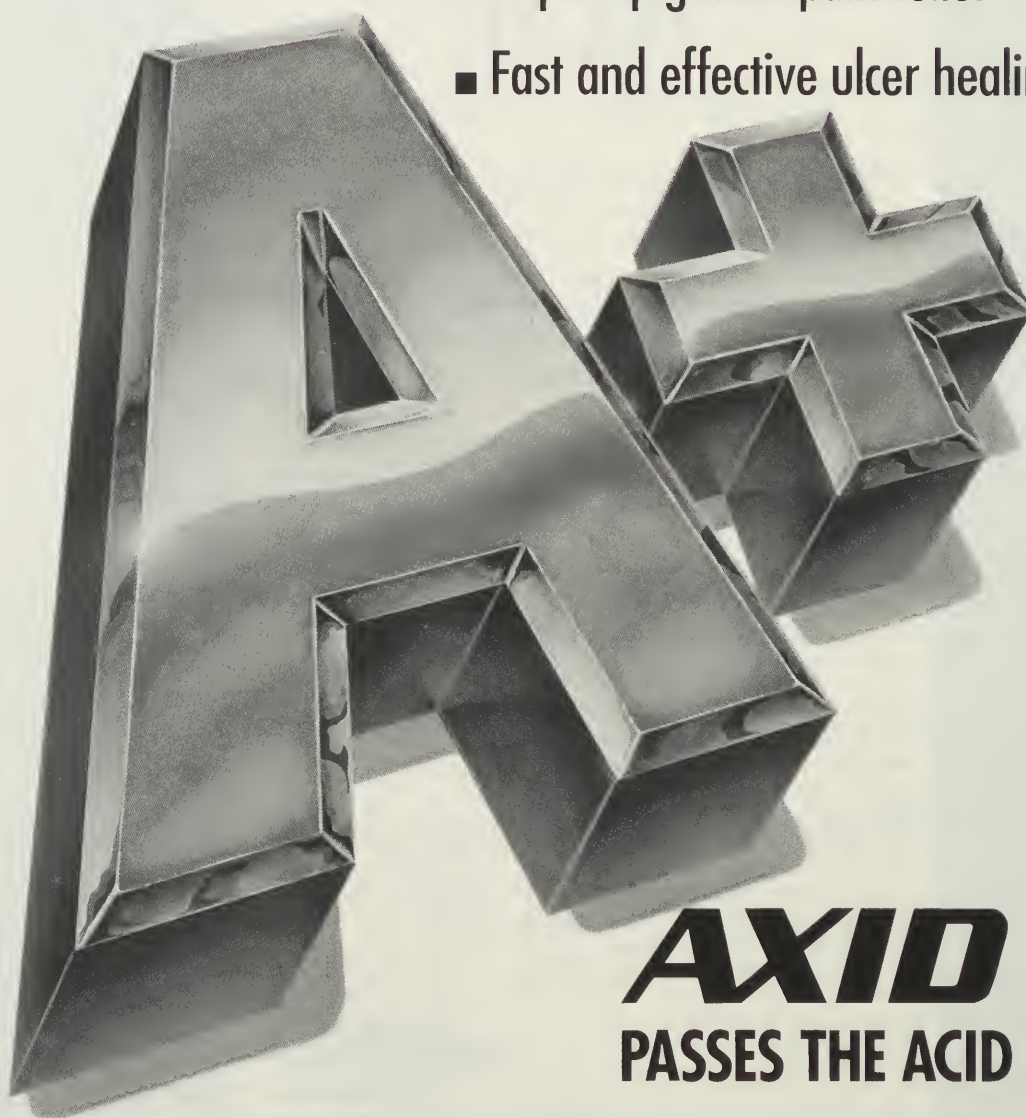
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Precautions: General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

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Drug Interactions—No interactions have been observed with theophylline, chlorazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L). The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of androgenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

PV 2091 AMP
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References

1. Data on file, Lilly Research Laboratories
2. *Scand J Gastroenterol* 1987;22(suppl 136):61-70.
3. *Scand J Gastroenterol* 1987;22(suppl 136):47-55.
4. *Am J Gastroenterol* 1989;84:769-774.

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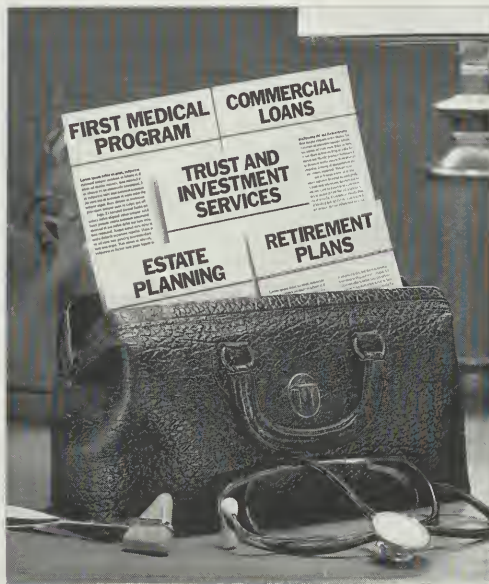
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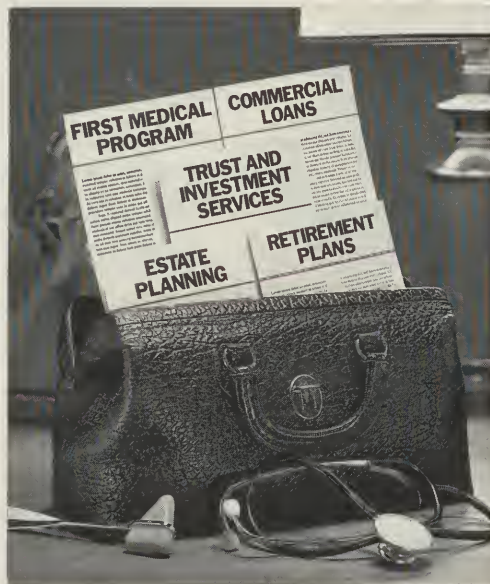
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Maryland Medical Journal

FEBRUARY 1992

VOLUME 41 NO 2

- George S. Malouf, Sr., M.D.—Recipient of the American Medical Association's Benjamin Rush Award for Citizenship and Community Service129**

Betsy Newman

"The American Medical Association recognizing me, a foreign medical graduate, for this prestigious award, could only happen because we live in America. I came to this land with dreams, but I never dreamt of a moment like this."

- Access to early cardiac care: Chest pain as a risk factor for heart attacks, and the emergence of early cardiac care centers133**

Raymond D. Bahr, M.D.

The tremendous advances in cardiac patient care are not being delivered to the majority of patients because the patients are entering the system too late and are not taking advantage of prodromal symptoms. Chest discomfort must be promoted as a risk factor and emergency room programs developed whereby patients can be checked out and treated early.

- The relationship of maternal race and insurance status to prenatal ultrasound use in a national population139**

Ronald G. Kaczmarek, M.D., M.P.H.; Roscoe M. Moore, Jr., D.V.M., Ph.D., D.Sc.; and Rosalie A. Bright, Sc.D.

Data from the first group of respondents (N=4,846) of the 1988 National Maternal and Infant Health Survey were analyzed. After controlling for potentially confounding factors, such as maternal age, in a multivariate analysis, no relationship could be demonstrated between insurance status or race, and the probability of receiving a prenatal ultrasound examination.

- Thalassemia screening in Baltimore145**

Allen D. Schwartz, M.D. and Ruth E. Luddy, M.D.

An education and screening program for β -thalassemia was offered to members of the Greek and Italian communities in the Baltimore area to allow for educated decisions regarding childbearing. Similar programs have been effective in decreasing the incidence of β -thalassemia major in other countries.

- Merkel cell carcinoma of the eyelid: A report of two new cases and a review of the literature149**

Howard L. Cummings, M.D. and W. Richard Green, M.D.

Merkel cell carcinoma is a cutaneous neoplasm that rarely occurs in the eyelid. The tumor has an aggressive nature with high local recurrence and metastases rates. Early diagnosis and prompt complete excision with frozen section monitoring of margins are recommended.



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Cover: George E. Malouf, Sr., M.D., an ophthalmologist in Prince George's County, recently received the American Medical Association's (AMA's) Benjamin Rush Award for Citizenship and Community Service. He is only the twentieth physician to be selected for this national honor.

Cover photo courtesy of Dimensions Health Corporation. Cover design and background illustrations by Susan Ventura.

Maryland's newest physical rehab center already has 20 years experience.



Baltimore is a city known internationally for its outstanding medical care. Now the tradition continues with the addition of the new Maryland General-Bryn Mawr Rehab Center at Maryland General Hospital. This specialty center for physical medicine and rehabilitation offers Bryn Mawr Rehab's 20 years of experience and leadership in the field of rehabilitation medicine.

The partnership between Maryland General Hospital and Bryn Mawr Rehab is truly unique. For the first time in Maryland, two high quality institutions with long histories of health care achievement are coming together to make a major commitment to rehabilitation medicine.

The Maryland General-Bryn Mawr Rehab Center, the region's most modern and conveniently located rehabilitation facility, provides a continuum of care in physical and cognitive rehabilitation services

including brain injury, stroke, orthopedics, arthritis, amputee services and multiple sclerosis, among others.

Most importantly, everyone on the Maryland General-Bryn Mawr Rehab team is personally and professionally dedicated to helping patients reach their highest level of independence. Our guiding philosophy is team-centered care, focused upon the individual needs of our patients and their families. This is what makes Maryland General-Bryn Mawr Rehab Center a very special place for rehabilitation care.

To learn more about Maryland General-Bryn Mawr Rehab Center or to arrange a tour, please call Mary Filippelli our administrative director at (301) 225-8380.

Maryland General-Bryn Mawr Rehab Center. We're the new team in town with lots of experience.



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WHY SHOULD YOU REFER CHILDREN AND ADOLESCENTS WITH SPINA BIFIDA TO CUMBERLAND HOSPITAL?

Cumberland Specializes in Child and Adolescent Care

Each year, some 200 pediatric patients ages 2-22 needing rehabilitation and behavior management are admitted to Cumberland Hospital for Children and Adolescents. While many hospitals provide excellent medical treatment, Cumberland adapts its programs to meet the social and psychological needs of young people.

Treatment is often incorporated into traditional adolescent activities. For example, treatment may include a basketball or volleyball game played in the gymnasium or the swimming pool. Individual mobility goals may be tested and explored during an outing to one of the local parks such as Busch Gardens (amusement park), Jamestown, Yorktown or Williamsburg.

For the young person with spina bifida, there is always a new challenge and a new opportunity to stretch his or her abilities and confidence.

Functional Mobility and Independence

The most visible and often most emotionally charged issue for the young person with spina bifida is mobility. Almost all children with spina bifida wear orthoses, and many use wheelchairs. Ambulatory skills are often achieved late and tend to reach a maximum in the 5- to 8-year-old age group.

With the approach of adolescence, there are increases in weight and height that make ambulation more difficult and less cosmetic.



Difficult decisions must be made regarding the young person's future. Cumberland assists patients and their parents in determining the form of mobility that is most acceptable to them, and help them structure their lives accordingly.

Adolescence is also a time when all young people begin to become independent, and independence for the young person with spina bifida means they take responsibility for their bowel and bladder program and for donning and doffing their braces.

Cumberland evaluates the gross and fine motor skills of the patients as well as their level of intellectual functioning. This information is needed to assist patients and their parents in setting reasonable expectations. Behavior and therapy programs are structured around these expectations.

Cumberland Is A Hospital

Cumberland is licensed by the Commonwealth of Virginia and accredited by the Joint Commission on Accreditation of Healthcare Organizations. It is one of only a few hospitals in the United States where all the physicians on the admitting staff are Board Certified in their specialty.



Cumberland Doesn't Look Like a Hospital

The hospital looks more like a small college with buildings connected by sidewalks, and picnic tables and recreation facilities are disbursed among the facilities. It is common to see young people in small groups talking, studying or

listening to music. Throughout the day, they go between the dormitory, cafeteria, rehabilitation, school and other buildings.

Depending on their level of physical abilities and behavior program, the young people are given levels of independence on the campus ranging from strict one-on-one staff supervision to free movement within the immediate environment.

Young People At Cumberland Go To School

One of the most important elements in the life of a young person is school, and at Cumberland patients go to school. Integrated into the hospital campus is Cumberland Academy—a licensed private school. The building includes classrooms, a library, prevocational department and gymnasium.

Course work is obtained from each patient's home school and classes are conducted around treatment and rehabilitation programs.

Cumberland Serves Many Different Young People

Cumberland provides treatment for young people with many types of medical and behavioral problems, and this has proved to be very beneficial for the patients with spina bifida. While there are usually a number of young people in the hospital with spina bifida, there are also patients with brain injury, diabetes, seizure disorders, spinal cord injuries, asthma and other conditions.

The young people quickly develop friendships and learn about the "disabilities and abilities" of the other young people. They leave the hospital with their medical needs treated and better able to cope with problems and challenges they encounter.

Cumberland's Setting

Cumberland is located on the Pamunkey River and is part of 1,200 acres owned by the hospital. There are three large lakes on the property for fishing and boating, and miles of trails.

For more information on Cumberland Hospital or to refer a patient for treatment, please call the information office at 1-800-368-3472.

**Cumberland Hospital
for Children and Adolescents**
New Kent, Virginia

The Personality Disorder Treatment Program of Sheppard Pratt Hospital

Very often, specialized inpatient evaluation and treatment is a critical step in the effective care of a borderline patient.

The Personality Disorder Treatment Program at Sheppard Pratt offers a combination of services that may help to untangle difficult clinical questions and facilitate your patient's continued outpatient treatment.

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- ☐ Comprehensive diagnostic evaluation
- ☐ Psychotherapy and psychopharmacology consultation
- ☐ Intensive individual and group psychotherapy provided by our staff of psychiatrists and psychologists
- ☐ Long-term treatment planning

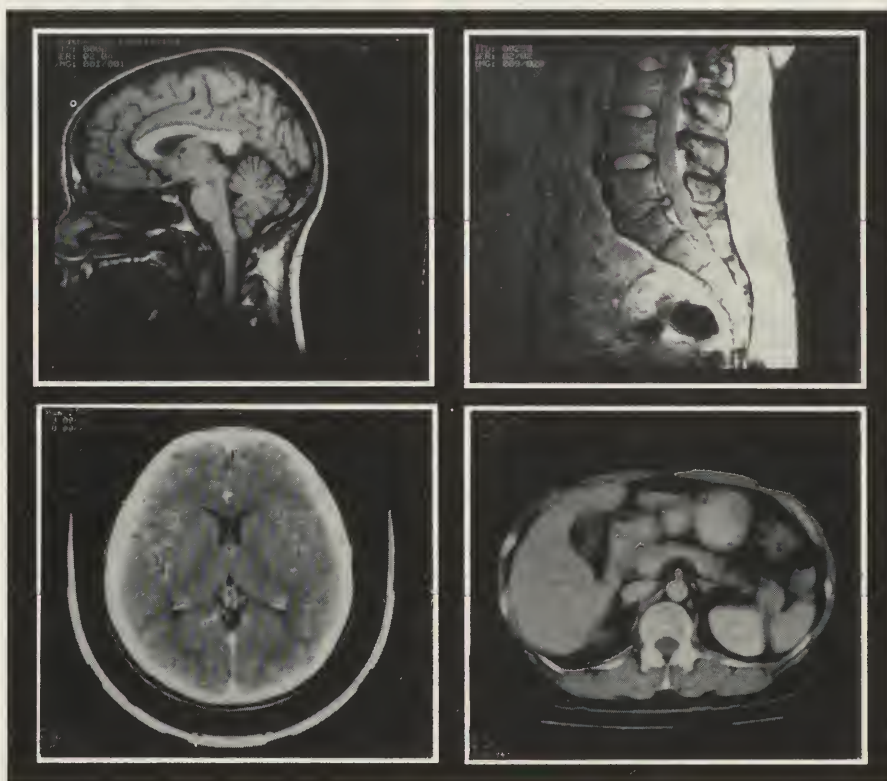
If you would like to know more about the Sheppard Pratt approach to the borderline patient and other patients with severe personality disorders, contact the Adult Admissions Office at:

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Executive Director's Newsletter

February 1992

Committee Selection Cards 1992-1993

Med Chi members interested in serving on a Med Chi committee during the 1992-1993 committee year, should complete the committee selection card following this newsletter. All members must complete this card to be considered for appointment.

Physician Volunteers for the Board of Physician Quality Assurance Needed

Med Chi is seeking practicing licensed Maryland physicians who are interested in serving as members of the Board of Physician Quality Assurance. Med Chi is responsible for submitting a list of physicians who meet this requirement to the governor. Med Chi is soliciting for volunteers from component medical societies and is advertising in the news media for volunteers to serve on the Board.

Med Chi membership is not required for appointment to the Board of Physician Quality Assurance

If you are interested in serving on the Board, please send your curriculum vitae, no later than March 16, 1992, to: Executive Director, Med Chi, 1211 Cathedral Street, Baltimore, MD 21201-5585

For more information, contact the Executive Director's office at 410-539-0872 or 1-800-492-1056.

Living Will and Durable Power of Attorney

To assist physicians in educating patients about living wills and durable power of attorney for health care, Med Chi has developed a brochure that clearly explains the importance and appropriate use of these documents. The brochure also includes a copy of a living will and a copy of a durable power of attorney for health care which can be signed and witnessed. To order copies of the brochure, call Lori Robinson in Med Chi's Communications Department at 410-539-0872 or 1-800-492-1056 or return the order form on page 188 of this issue.

Effective December 1, 1991, the new federal Patient Self-Determination Act requires that all hospitals, nursing homes, etc. receiving Medicare and Medicaid must inform patients over the age of 18 of their right to prepare an advance directive or living will that would instruct health care providers to remove life-sustaining equipment in the event the patient becomes terminally ill. Although physicians are not subject to the provisions of the law, it is important that physicians understand the nature of both these documents.

Annual Meeting

"Mini-invasion and Megatreatments" is the theme for Med Chi's 1992 annual meeting to be held at the Omni Inner Harbor Hotel in Baltimore on Thursday, April 30, Friday, May 1, and Saturday, May 2, 1992. Referring to the use of scopes in surgical and non-surgical diagnosis and treatment, as well as massive doses of radiation, the theme encompasses a wide range of specialties and

procedures that have been enthusiastically received by patients and physicians alike. Physicians attending the meeting will have the opportunity to learn about these new technologies and earn CME credits.

Social events at the meeting include an Inner Harbor cruise with dinner and dancing aboard Baltimore's Bay Lady on Thursday, April 30. On Friday, May 1, doctors and their families will be invited to visit the new Oriole Park at Camden Yards and watch the Orioles take on the Seattle Mariners. On Saturday, May 2, physicians may attend Med Chi's Presidential Banquet honoring Med Chi President J. David Nagel, M.D.

A preliminary program listing scientific programs and registration information for the meeting will be featured in the March *Maryland Medical Journal*. For more information about the meeting, contact Vivian Smith at 410-539-0872 or 1-800-492-1056.

House of Delegates and Council Meetings

Med Chi House of Delegates and Council will meet at the following times during Med Chi's 1992 Annual Meeting at the Omni Inner Harbor Hotel in Baltimore:

Friday, April 30, 1992

Council 8:30 a.m.

House of Delegates 9:30 a.m.

Saturday, May 2, 1992

House of Delegates 2:00 p.m.

Council 3:00 p.m.

President's Regional Conference —Southern Maryland

The President's Regional Conference for southern Maryland will be held on Tuesday, March 10, 1992, at 4:30 p.m. at the Solomons Island Holiday Inn. The program will feature updates on important Med Chi issues and a presentation on the AMA's Health Access America; CME credits will be offered. Watch the Executive Director's Newsletter for more information about this conference or contact Betsy Newman, public relations director, at 410-539-0872 or 1-800-492-1056.

InforMed Program

For several years, Maryland law has required that hospitals in the state submit patient discharge data to the Health Services Cost Review Commission (HSCRC), the agency that sets rates for Maryland hospitals. Because these data provide sensitive information regarding physician practice patterns, individual physicians are not identified except through a unique number assigned by Med Chi. Last year, Med Chi received a large number of requests from physicians to release the confidential identifying number to an organization known as Barton-Gillett Physician Services. At first, Med Chi refused to comply with the release requests because Med Chi was not convinced that disclosure was either allowed by law or in the best interests of the medical community.

Since then, Med Chi leadership has met with representatives of the HSCRC and of Barton-Gillett, and has agreed to provide the identifier number upon proper request by physicians who wish to participate in Barton-Gillett's InforMed Program. In return, Med Chi has been given assurances that Barton-Gillett is not owned by any third-party payor and that it will protect the sensitive data from improper disclosure. As explained by Barton-Gillett, InforMed is a volunteer medical accounting program that will show individual physicians how their practice patterns compare with statewide and regional averages in the same specialties. Med Chi believes that this type of information may be valuable to a physician in managing his or her own practice in a cost-effective manner without sacrificing quality of care. In fact, access to such data through InforMed may also assist the physician in dealing with third-party payors. For further information on Med Chi's position on InforMed, contact Med Chi's legal department at 410-539-0872 or 1-800-492-1056.

Doctor/Lawyer/Teacher Partnership

On February 4 to April 10, 1992, physician volunteers will visit more than 30 Baltimore city schools and talk to over 2,500 students about the medical dangers of using alcohol and drugs. If you are interested in volunteering for this program in Baltimore city or if you would like information about doctor/lawyer programs in your area, contact Betsy Newman, public relations director, at 410-539-0872 or 1-800-492-1056.

Murray Promoted to AMA Vice-president

Michael A. Murray, who served as assistant executive director of Med Chi for a number of years before joining the American Medical Association (AMA) staff in March 1990, recently was made AMA vice-president for state and county relations. In this new capacity, he will be responsible for managing liaison activities involving the AMA and all state and county medical societies. Most recently, Murray assisted Med Chi in obtaining two grants to promote AMA's Health Access American program in Maryland. Med Chi congratulates Mike on his continuing success at the national level.

Computers in the Medical Office

Med Chi's Computers in Medicine Committee is sponsoring "Computers in the Medical Office," a three-part seminar on Saturday, March 7, 1992, from 9 a.m. to 2 p.m. in the Med Chi Faculty Building. The seminar is intend for physicians who want to expand their office computer capabilities or for doctors who do not yet have computer equipment and need guidance in the selection of hardware and software.

The first part of the seminar will review computerizable office functions and various examples of software that will meet those functions. The second part of the seminar will address the hardware requirements as determined by needed software and practice

size. The third part of the seminar will be hands-on demonstrations of computer equipment by all participants. Registration for the seminar is \$20. For more information, contact Bruno Mattiello at 410-539-0872 or 1-800-492-1056.

Registration Form

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Saturday, March 7, 1992*

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Baltimore, MD 21201-5585

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Fax 410-547-0915


Angelo J. Troisi, F.A.C.H.E.
Executive Director

Each year Med Chi requests physicians to serve on its more than 45 committees. These committees are the backbone of our organization and guide the decisions made by Med Chi's House of Delegates, Council and Executive Committee. To assure that Med Chi remains a strong and active organization, it is essential that physicians participate as active members of these committees.

As President for 1992-93, I intend to appoint as many physicians as possible to committees. Please indicate your willingness to serve by checking your preference and special interests on the attached reply card. Every effort will be made to appoint you to the committee of your choice.

Med Chi is your organization. By serving on a Med Chi committee, you can help protect and improve Maryland medicine.

Thank you for your assistance

Jose M. Yosunico MD
President-elect

I am interested in serving on the following Med Chi committee(s):

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Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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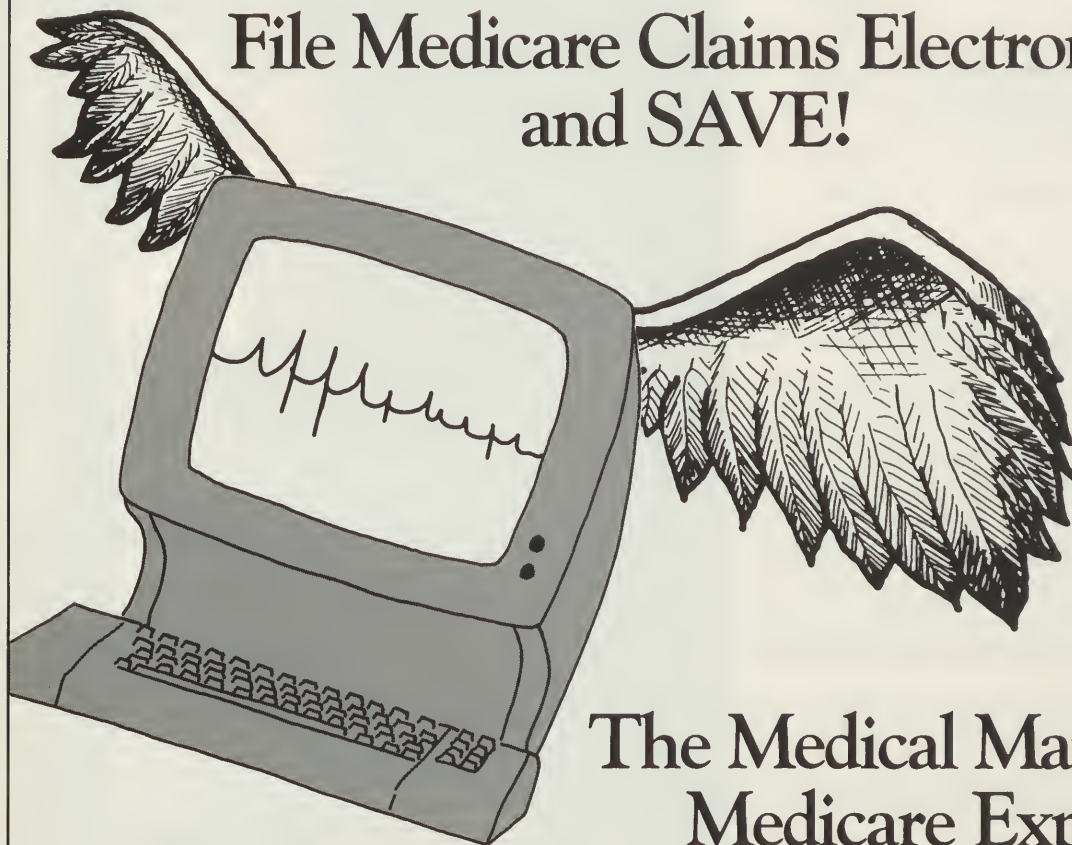
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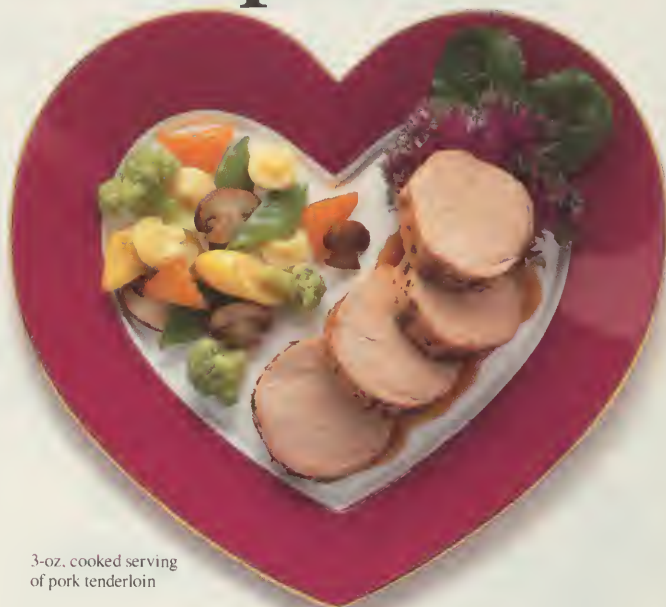
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Today's Pork: Compare it to chicken for a healthy surprise

You may not have considered pork to be a healthy choice for your patients on fat-modified diets. But today's fresh pork compares surprisingly well to chicken in total fat, saturated fat, cholesterol, and calories.^{1,2*}

Compare pork with chicken^{1,2*}

	Calories	Total Fat	Saturated Fatty Acids	Cholesterol
Chicken Breast, skinless	140	3.0 g	0.9 g	72 mg
Pork Tenderloin, trimmed	139	4.1 g	1.4 g	67 mg
Pork Top Loin Roast (boneless), trimmed	165	6.1 g	2.2 g	66 mg
Center Loin Chop, trimmed	172	6.9 g	2.5 g	70 mg
Chicken Thigh, skinless	178	9.2 g	2.6 g	81 mg

*Table refers to 3-oz. cooked servings.

New study: Pork is now 31% leaner

Pork is leaner today because of significant changes made in breeding and feeding techniques. According to new 1991 official USDA data, fresh pork sold today contains an average of 31% less fat after cooking and trimming than the same pork cuts reported in 1983.¹

Today's pork fits well within the dietary guidelines recommended by both the American Heart Association and the National Cholesterol Education Program. Here's some advice to help patients on low-fat diets enjoy the variety, extra taste, and versatility of pork:

- Choose the leanest cuts. Shop for cuts with "loin" in the name.
- Trim away any visible fat.
- Keep portions moderate (about 3 oz, cooked).
- Prepare by broiling or roasting, and avoid additional fat in preparation.

1. US Dept of Agriculture. *Composition of Foods: Pork Products*, 1991. Agricultural handbook 8-10.

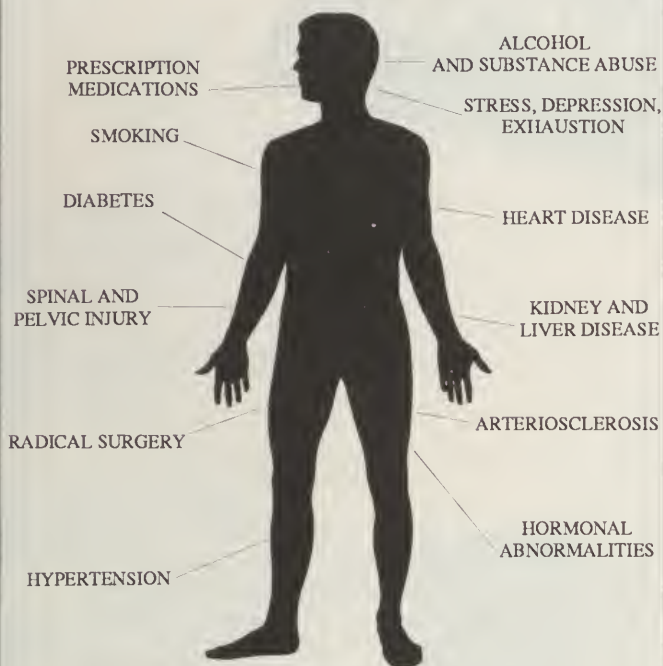
2. US Dept of Agriculture. *Composition of Foods: Poultry Products*, 1979. Agricultural handbook 8-5.

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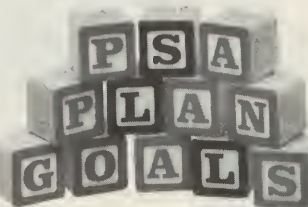
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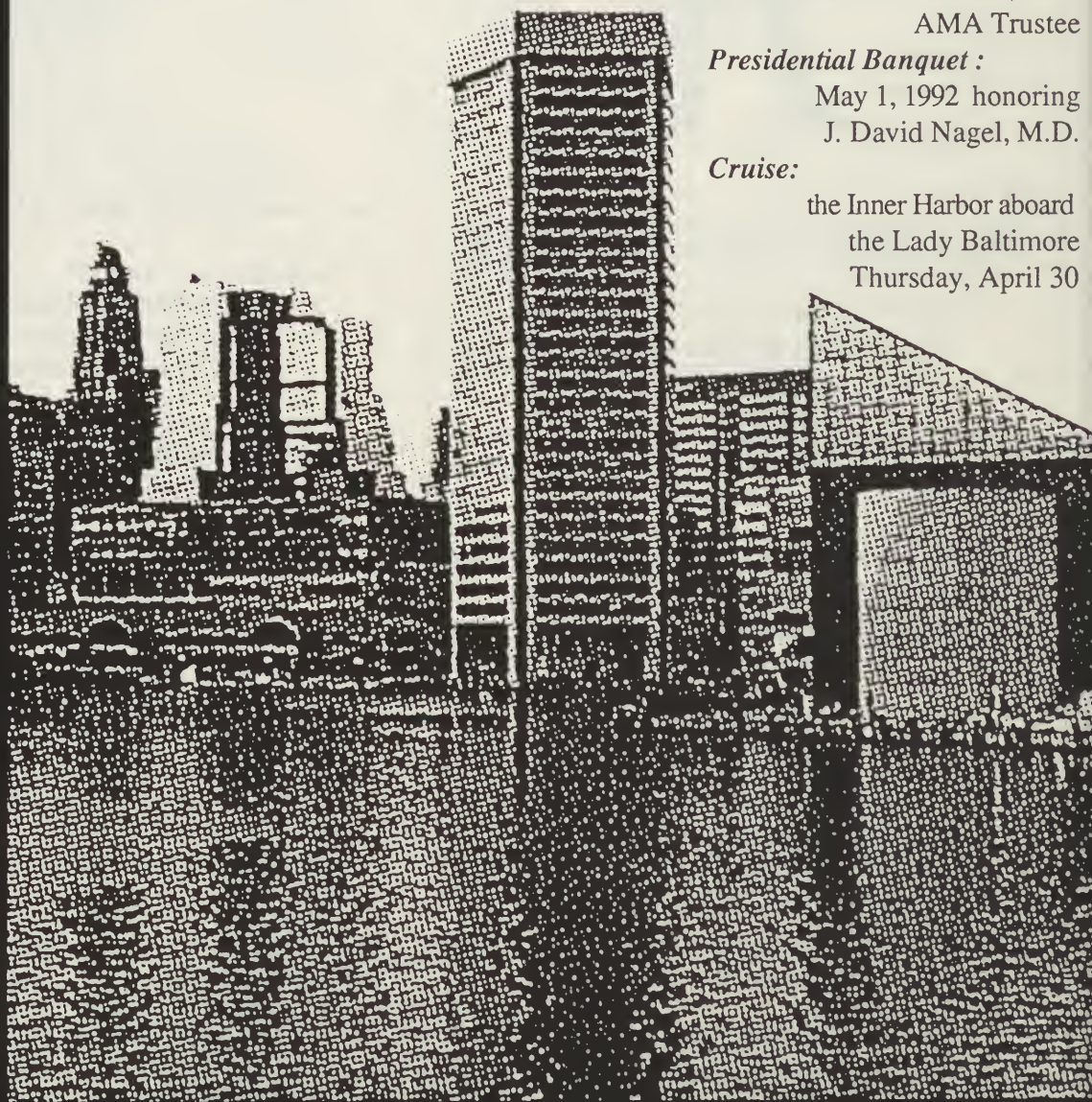
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May 1, 1992 honoring
J. David Nagel, M.D.

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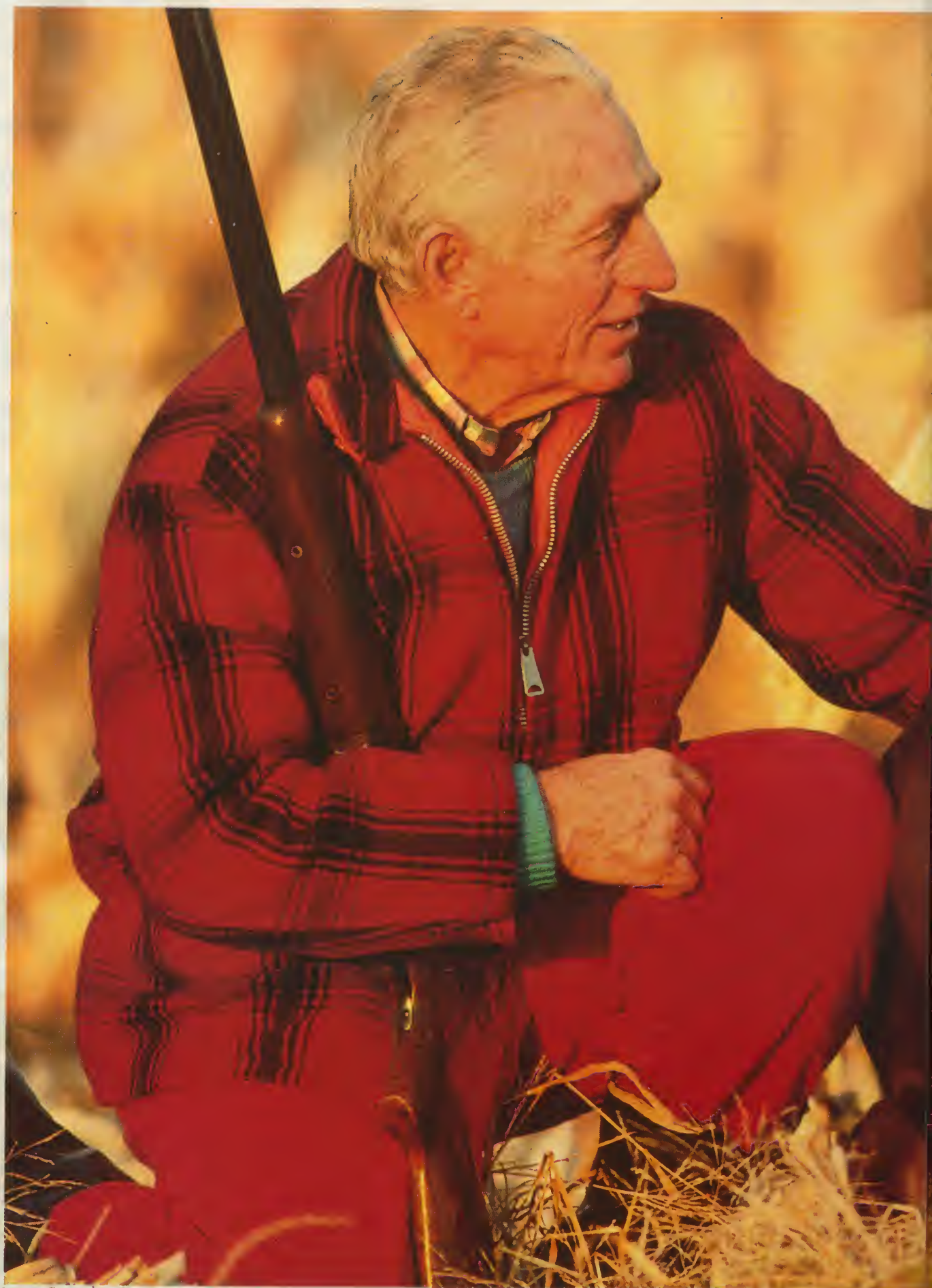
MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND

Keep cigarette ads out of the waiting room

Med Chi supports the AMA's policy, as stated in substitute resolution 13, which reads as follows: "Resolved, That the American Medical Association annually, via *JAMA* and other appropriate publications, publish a list of those magazines that have voluntarily chosen to decline cigarette ads; and encourage physicians to substitute magazines without cigarette ads for those with cigarette ads in their office waiting rooms."

Two reception room subscription services make it easier to select tobacco ad-free magazines. A lengthy offering, arranged by subject, may be obtained by writing to EBSCO Reception Room Subscription Services, Top of Oak Mountain, PO Box 830460, Birmingham, AL 35282-9720 or to Subscription Services Reception Room Magazine Program, 29 Glen Cove Ave., Glen Cove, NY 11542. You may also write directly to any of the publications on the list below.

3-2-1 Contact	Home Office Computing	Popular Communications
Adirondack Life	Horticulture	Popular Photography
Air & Space	Humpty Dumpty's Magazine	Popular Woodworking
Alaska	Hunting	Practical Homeowner
American Baby	Income Opportunities	Prevention
American Health	International Travel News	Railfan and Railroad
American Heritage	Isaac Asimov's Science Fiction	Ranger Rick
American History Illustrated	Jack and Jill	Reader's Digest
Analog Science Fiction	Kid City	Runner's World
Animal Kingdom	Ladybug	Sail
Artist Magazine	MacUser	Saturday Evening Post
Arizona Highways	MacWorld	Science
Audubon	MAD Magazine	Science News
Aviation Week & Space Technology	Maine Fish & Wildlife	The Sciences
Backpacker	Maine Life Magazine	Scientific American
Bicycling	Mayo Clinic Health Letter	Sesame Street
Boy's Life	Men's Fitness	Seventeen
Business Week	Men's Health	Shape
Byte	Midwest Living	Sierra
Cat Fancy	Model Railroader	Skin Diver
Child	Modern Maturity	Smithsonian
Consumer Reports	Montana Magazine	Southern Accents
Cooking Light	Mother Earth News	Sports Afield
Craft Works for the Home	Mother Jones	Stork
Cricket	Muscle & Fitness	Sunset
Cyclist	Nation	Teen
Dance Magazine	Nation's Business	Theatre Crafts
Dog Fancy	National Geographic	Travel Holiday
Down East Magazine	National Parks Journal	Utah Holiday
Executive Edge Newsletter	Natural History	Vegetarian Times
Farm Journal	New Age Journal	Venture Magazine
Fishing Facts	The New Yorker	Vermont Life
Flower & Garden	North American Review	Video Review
The Futurist	Nutrition Action Healthletter	Virtue
Golf Illustrated	Oceans	Walking
Good Housekeeping	Old House Journal	The Washington Monthly
Guideposts	Organic Gardening	Weight Watchers
Hadassah Magazine	Parenting	Western Outdoors
Harvard Business Review	Parents	Women's Sports & Fitness
Harvard Medical School Health Letter	PC Magazine	Workbasket
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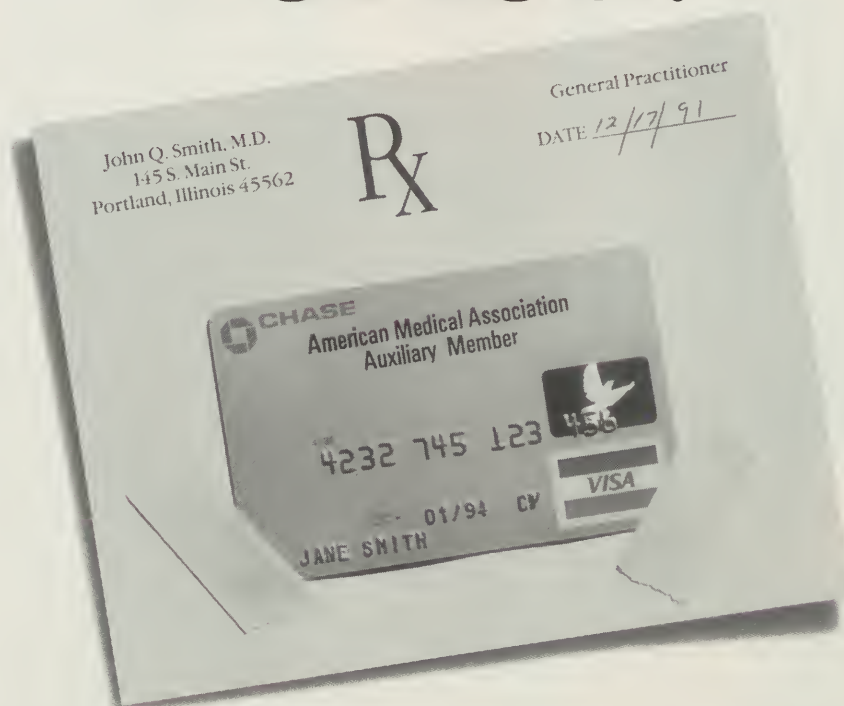
In fact, about the only thing he regrets is having to sit still while infusing. And for George Atwood, that's the hardest part of all.

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Auxiliary

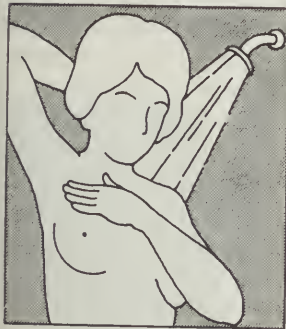
Breast cancer awareness

The Auxiliary's fall house of delegates meeting was held in October, which happens to be Breast Cancer Awareness Month. President Vivian Lynn has made breast cancer the focus for the Auxiliary and the special topic for Health Projects. The fall meeting was held in Harford County and the principal speaker on the first day was Auxilian Bea Sadowsky (Mrs. Wallace) from Harford County, who spoke about her work with "Reach to Recovery." She brought us many insights gained in the 25 years since her own surgery. "Reach to Recovery" is an outreach program sponsored by the American Cancer Society for post-mastectomy patients. Women, who have been through this experience, bring patients a special bag of useful gifts and materials, and are available to talk, explain, and help patients during their recovery (Figure 1).

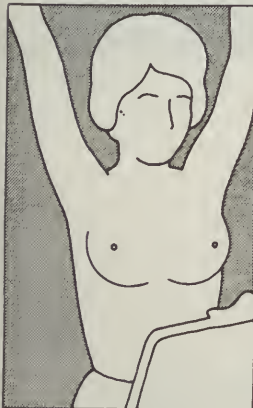
On the second morning of the meeting, Dr. Faysal Mudarris, a Harford County radiologist, presented a slide show on mammography. He explained what the radiologist looks for, discussed the technology involved, and reinforced the need for regular testing in all women.

Ms. Patti Wilcox, RN, director of the Johns Hopkins Oncology Consultation Unit, was the luncheon speaker. Ms. Wilcox has had many years of experience through teaching, counseling, and offering support to women who have had breast cancer. She gave specifics on self-examination (Figure 2) and provided special information for women in

HOW TO EXAMINE YOUR BREASTS:



1 IN THE SHOWER:
Examine the entire area of each breast in the bath or shower, since fingers glide more easily over wet skin. Check for any lump or thickening.



2 BEFORE A MIRROR:
Inspect your breasts first with arms overhead, and then by placing hands on hips and flexing your chest muscles. Look for any changes, i.e., dimpling or swelling.



Figure 1. Beatrice Sadowsky of Harford County holds a "Reach to Recovery" bag filled with useful gifts and materials.

high-risk families. Through the use of videos and slides, she presented a very clear and informative talk. Ms. Wilcox may be reached at the Johns Hopkins Oncology Consultation Unit, 550 North Broadway, Suite 1003, Baltimore, MD 21205 (410-955-4850).

Materials from the Cancer Information Service were distributed (Figure 3) and videos from the American Cancer Society, Maryland Division, were shown.



Figure 3. Participants at the October meeting were provided with free materials from the Cancer Information Service.



3 LYING DOWN:
To examine your right breast, place a pillow or folded towel underneath your right shoulder and place your right hand behind your head. With fingers flat, press each breast in small, circular motions around an imaginary clock face. Repeat for the left breast. Then, squeeze each nipple. Any discharge should be promptly reported to your physician.



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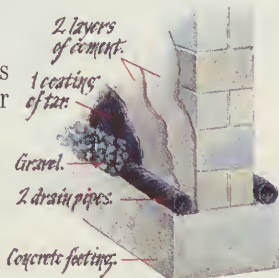
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Potomac's Family Community

Look behind the glitz for the hidden values. Quality construction that saves you time, trouble and money through the years.

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"My grandfather taught my father and my father taught me."

Auxiliary

Posters, newspaper clippings, and magazine articles were available to give further information. All the materials used at the meeting were obtained without charge from the American Cancer Society and the Cancer Information Service. For your convenience, information and free materials may be obtained by writing or calling the following: (a) Cancer Information Service, 550 North Broadway, Suite 307, Baltimore, MD 21205 (1-800-4-CANCER) or (b) American Cancer Society, Maryland Division, Inc., North Central Maryland area, 8219 Town Center, P.O. Box 43025, Baltimore, MD 21236 (410-823-2515 or 529-6500). All county auxiliaries are urged to take advantage of the resources of these organizations and to use them at their meetings.

The Auxiliary's focus on breast cancer will continue throughout the year. The speaker for the winter board meeting, to be held at Med Chi in February, will be Sandy Kolodny, coordinator for the University of Maryland's mammography van. This van travels to all parts of Maryland to perform low-cost or no-cost mammography examinations.

We think this emphasis on breast cancer is extremely timely and believe this is a message that will be useful to all. Vivian Lynn has chosen a direction we should all try to follow.

MILDRED TAYLOR
and CHING BARRETTO
Health Projects Chairpersons

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Accelerated non-surgical treatment for the most advanced cases.

The physicians at Vein Clinics of America have successfully treated venous leg ulcers—including advanced cases—in our offices without the use of surgical procedures.

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Rapid closing of ulcer.

The common denominator of most leg ulcers is venous pump failure with edema. Our treatment first removes the edema and heals the ulcer through the application of isometric compression bandaging. This increases venous outflow during ambulation, resulting in improved pump action at the calf muscle.

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Before treatment. Patient shows chronic ulcer with subcutaneous tissue damage from years of inflammation.

include immediate ambulation, rapid elimination of pain and drainage and high patient acceptance.

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After one week of isometric compression bandaging.



After two weeks.



Ulcer closed in three weeks.



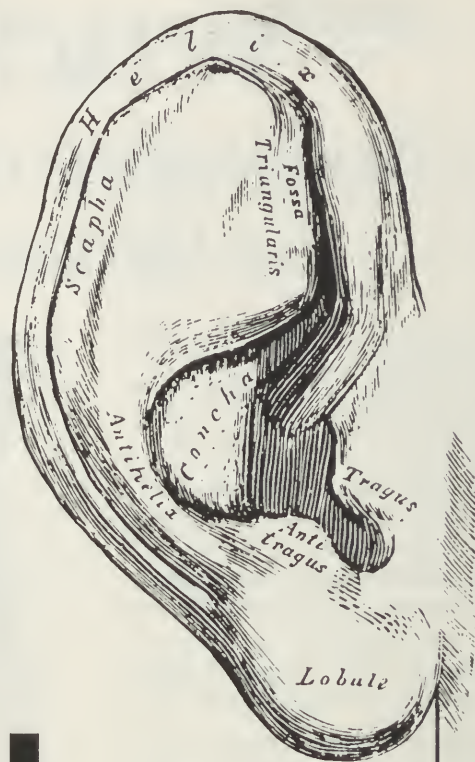
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Enter the Twelfth Annual Med Chi Photo Contest

Deadline for entries is Friday, April 3, 1992 ● Two categories: Black & White or Color ● Open to all Med Chi and Auxiliary Members ● First and Second Prizes Awarded In Each Category ● All Photographs will be displayed at the 1992 Annual Meeting at the Omni Inner Harbor Hotel in Baltimore.

Photo Contest Rules

Eligibility: All members of the Faculty and members of the Auxiliary to the Medical and Chirurgical Faculty may enter. Professional photographers may not enter. Members of the Photo Contest Committee and their families are not eligible.

1. Photographs may be submitted in two categories: black and white or color.
2. Limit: three entries per person.
3. Prints only, no smaller than 8 x 10" or larger than 11 x 14", will be accepted. If your favorite shot is a slide, you must have a print made within these size ranges to enter the contest.
4. Entries must be matted or dry mounted. No framed photographs will be accepted.
5. Entries must have name, address, and telephone number attached to the back of each photograph.

6. Entries may be mailed or brought to Med Chi, 1211 Cathedral Street, Baltimore, Maryland 21201 by the close of the business day on April 3.
7. Photographs entered in the contest will be on display at the 1992 Annual Meeting.
8. Prizes will be awarded to the first and second place winners.
9. Winners will be announced at the Annual Meeting of the Medical and Chirurgical Faculty, April 30 – May 2, 1992.
10. Photographs will not be mailed back. Photographs may be claimed at the exhibit area at the close of the Annual Meeting at noon on May 2, or at Med Chi thereafter.
11. Med Chi does not guarantee against loss or damage of any kind to the photographs submitted to the contest.

George S. Malouf, Sr., M.D.

Recipient of the American Medical Association's Benjamin Rush Award for Citizenship and Community Service

Betsy Newman

Ms. Newman is director of public relations, Medical and Chirurgical Faculty of Maryland, Baltimore, MD.

"The American Medical Association recognizing me, a foreign medical graduate, for this prestigious award, could only happen because we live in America. I came to this land with dreams, but I never dreamt of a moment like this."

"This is a great country that we live in," says George S. Malouf, Sr., M.D., recipient of the 1991 American Medical Association's (AMA) Benjamin Rush Award for Citizenship and Community Service. Dr. Malouf received a Galvano Medallion and a \$2,500 stipend at the AMA's 1991 Interim Meeting in Las Vegas, Nevada on December 8, 1991. He is only the twentieth physician to be selected for this national award. A foreign medical graduate, Dr. Malouf feels honored to be associated with Dr. Rush, a signer of the Declaration of Independence. "To be identified with such a great American patriot and physician is certainly something of which I am very proud."

The Benjamin Rush Award

The AMA's Benjamin Rush Award is presented to physicians who have made an outstanding contribution to the community for citizenship and public service that is above and beyond the call of duty of a practicing physician. One of the most influential physicians in America from 1761 to 1813, Dr. Benjamin Rush was also known as a social reformer and citizen. He was one of the four physician signers of the Declaration of Independence, a member of the Continental Congress, physician general of the Continental Army, and a member of the Pennsylvania convention that ratified the Constitution.

Like Dr. Rush, Dr. Malouf is also a great American patriot and was singled out for this honor because of his numerous outstanding contributions to Prince George's County, Maryland, and the United States. "I believe it is very important for physicians to be aware of the needs of their community," says Dr. Malouf. "I also believe the community should be aware of quality medical care. Somehow, in all of my endeavors, I try to achieve this union."

Medicine and the community

Dr. Malouf realizes this union in his own practice. Since he opened his Hyattsville ophthalmology practice in 1958, Dr. Malouf has earned a

reputation as a caring physician and community leader. He continuously demonstrates a profound concern for all people, especially the needy.

To meet the medical care needs of the indigent citizens in rural Baden, Maryland, Dr. Malouf was instrumental in bringing Baden Health Services to its fruition. "Baden was an area in need of physicians," says Dr. Malouf. "Although I'm not from southern Maryland, I was very active in creating the board to recruit physicians to that community." He also personally met with a variety of individuals and groups, procured a site, obtained materials, and supervised the activities for this essential health service. The clinic now provides medical care to over 15,000 residents in the Baden area.

To assist the impoverished children in Prince George's County, Dr. Malouf is a trustee of the Magruder Trust which helps fund medical care for these children. He has also served as a member of the Health Planning Committee of Prince George's County and is a trustee of the Prince George's Medical Charitable Foundation.



Dr. Malouf thanks AMA President John J. Ring, M.D. for the Benjamin Rush Award.



AMA President John J. Ring, M.D., Eva Malouf, George S. Malouf, Sr., M.D.

The ecumenical principle

Dr. Malouf's activities extend far beyond the realm of the medical community. In the early 1970s, he became aware of the need to establish a church for the Lebanese Catholic community in the Washington, DC metropolitan area. "I believe in the ecumenical principle and I felt that I should help in some way," says Dr. Malouf. Dr. Malouf, who is not Catholic, dedicated an enormous amount of time, energy, and finances to establish the Melkite Catholic Church of Washington, DC. The congregation named him "Man of the Year" in 1971.

An active member in his own church, the St. George Orthodox Church in Washington, DC, Dr. Malouf has served as president and member of the council. He has been a member on the board of trustees for the Antiochian Christian Orthodox Church of America and received the Antiochian Medal of Merit in 1981.

The Lebanese war

Dr. Malouf's altruistic efforts exceed our national boundaries. Following the deaths of 242 U.S. Marines during the bombing of a marine barracks in Beirut, Lebanon, Dr. Malouf helped his wife Eva, who chaired the committee, raise thousands of dollars for the Beirut Marine Relief Fund to assist the surviving family members of the deceased Marine Corps personnel. Following this effort, the U.S. Marine Corps issued a proclamation stating its sincere appreciation for this fund. "I was very much affected by the Lebanon war and felt compelled to do something about it," says Dr. Malouf. "I felt honored in joining the committee working with the Lebanese Embassy in an effort to help many of the people who were injured."

Dr. Malouf became the focal point for physicians who graduated from the American University of Beirut, helping them find residency in the United States."

His tremendous amount of community involvement both at home and abroad has earned him numerous awards. In recognition of his close liaison and hundreds of hours of community service, the Lebanese government has bestowed on him a special decoration.

In the United States, Dr. Malouf's accomplishments have been applauded at both the county and state level. In 1984, the Prince George's County Council and the county executive issued a proclamation applauding the efforts of Dr. Malouf. Later that year, the Maryland Senate passed a resolution recognizing and congratulating him for his "outstanding dedication to the citizens of Prince George's County and for bringing great credit to the profession of medicine." In 1987, Med Chi presented him with the A.H. Robins Physician of the Year Award for outstanding community service.

Prince Georgian of the Year 1988

In April 1988, Dr. Malouf was named Prince Georgian of the Year. Selected from a field of over 200 nominees, Dr. Malouf was the first person to receive this honor for his

contributions that had a "significant impact on the lives of their neighbors and all of the residents of Prince George's County, making our communities good places in which to live and work." On April 7, 1988, the Maryland Senate again recognized him for his "outstanding accomplishments which have significantly enhanced the quality of life in Prince George's County." The Maryland House of Delegates passed a similar resolution the following day. In May of that year, he received a governor's citation for his "deep commitment to your fellow citizens of Maryland...as demonstrated by your pioneering efforts in the field of ophthalmology and your distinguished record of community service...."

The AMA's Dr. Benjamin Rush Award is the first national recognition Dr. Malouf has received for his community involvement. Upon receiving the award, Dr. Malouf presented the \$2,500 stipend check to Med Chi President J. David Nagel, M.D. The money will be used to start a foundation to provide for lectures and "other methods of sharing this great honor among the people of Maryland."



In 1987, George S. Malouf, Sr. M.D. received the A.H. Robins Award for Community Service from Ted Lewers, M.D.

Family and background

"This award is a great tribute to me and my family," says Dr. Malouf who has lived with his wife, Eva, in College Heights Estates in Prince George's County for over 30 years. They have four children: Mrs. Carol Mufarrij, George S. Malouf, Jr., M.D., Mrs. Vivian Zalzal, and Alan Malouf, M.D.

Born in Zahle, Lebanon, Dr. Malouf came to the United States after earning a doctorate in medicine from the French Faculty of Medicine in Beirut, Lebanon. After completing five years of residency training at Boston City Hospital, Dr. Malouf became a member of the American Board of Ophthalmology. He served two years in the U.S. Army Medical Corps where he earned a Certificate of Achievement for his outstanding performance, leadership ability, and professional knowledge.

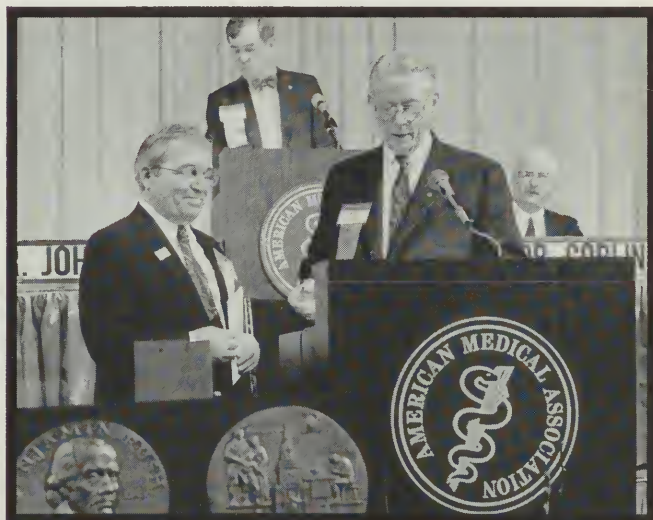
Dr. Malouf now practices in Hyattsville, Maryland with his two sons and maintains a very active role in medicine. He



AMA President John J. Ring, M.D. (C) and George S. Malouf, Sr., M.D. and his wife, Eva Malouf, look on as Med Chi President J. David Nagel (R) congratulates Dr. Malouf on his receipt of the Benjamin Rush Award.

is the chief of the Division of Ophthalmology at Prince George's Hospital and Medical Center where he and George Malouf, Jr., M.D. performed the first cornea transplant in Prince George's County. He has served as president of the hospital's medical staff and now sits on the board of directors. He is the former chief of ophthalmology at Doctor's Hospital of Prince George's County. He is a member of the board of directors of Community Hospital and Health Systems of Prince George's County, which oversees the operation of the three county-owned hospital facilities. He is also a founding member of the Health Planning Committee of Prince George's County.

Dr. Malouf plays a major role in organized medicine. A member of the Prince George's County Medical Society, Dr. Malouf served as its president in 1975. At the state level, he was Med Chi Council chairperson for two consecutive years before he was elected Med Chi president in 1984; he was the



AMA President John J. Ring, M.D. (R) presents George S. Malouf, Sr., M.D. (L) with the stipend check for the Benjamin Rush Award.

first foreign medical graduate to hold that office. Dr. Malouf is currently a delegate to the American Medical Association. He is also a charter member of the Maryland Society of Eye Physicians and Surgeons where he served as its first vice-president in 1980 and became president in 1981.

To his colleagues, Dr. Malouf is known as a peacemaker—a person who can bring both sides together for a common goal. To his community, Dr. Malouf is recognized as a devoted humanitarian whose accomplishments have inspired many.

**Benjamin Rush Award
for Citizenship and Community Service
Acceptance Speech**

**by
George S. Malouf, Sr. M.D.**

**Presented at the
American Medical Association Interim Meeting
in Las Vegas, Nevada
on December 8, 1991.**

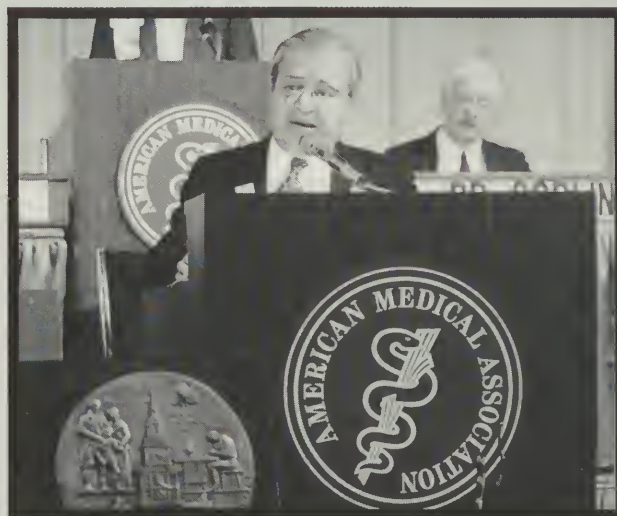
Mr. President, Mr. Speaker, members of the Board of Trustees, distinguished guests, fellow delegates: I accept this great honor, the Benjamin Rush Award, with sincere gratitude and a deep feeling of humility. I am grateful to the Board of Trustees of the American Medical Association for choosing me. Being recognized by the highest body of my peers gives me a thrill and a feeling of pride that will live with me forever.

I am also grateful to my immediate family. To my wife Eva for being a great inspiration and loving friend throughout the years. To my sons and daughters and their spouses for being always on my side, helping and cheering my efforts. I am also indebted to my extended family: the Prince George's County Medical Society and the Medical and Chirurgical Faculty of Maryland. They have provided me with love and support for the last three decades. It is for them and in their name that I accept this award.

The American Medical Association recognizing me, a foreign medical graduate, for this prestigious award could only happen because we live in America. I came to this land with dreams but I never dreamt of a moment like this.

Linking my name to that of Benjamin Rush, a member of the Continental Congress, a signer of the Declaration of Independence, a great physician, and a great American patriot, is overwhelming and humbling. Recognizing my contribution to citizenship and community service should

Yet despite his activities and honors, Dr. Malouf is humble. "This award isn't meant to symbolize what I've done," he says." This award is a symbol of the greatness of the American Medical Association and our nation. In his acceptance speech to the AMA (see box), Dr. Malouf said, "The American Medical Association recognizing me, a foreign medical graduate, for this prestigious award, could only happen because we live in America. I came to this land with dreams, but I never dreamt of a moment like this." ■



George S. Malouf, Sr., M.D. gives his acceptance speech.

be a recognition of the magnificence of the American spirit, the greatness of this nation and the everlasting solid principles on which it stands.

Yesterday the winds of freedom stormed through the world, crumbling walls built to separate nations. That same wind continues to pass over America but it turns into a gentle breeze blessing and caressing our country as we enter with more conviction and determination the third century of our history.

Whatever achievements I have attained in my life and whatever contributions I have provided are minuscule. However, Mr. President, I would like to lay them as a token "gift of gratitude on the lap" of the American Medical Association and this great nation. It is my way of saying thank you and God bless America. ■

*Quotation from Khalil Gibran. I believe in you. In: *Mirrors of the Soul*. New York: Philosophical Library. 1965; 34.

Access to early cardiac care: Chest pain as a risk factor for heart attacks, and the emergence of early cardiac care centers*

Raymond D. Bahr, M.D.

Dr. Bahr is medical director, the Paul Dudley White Coronary Care System, St. Agnes Hospital, Baltimore, MD.

The tremendous advances in cardiac patient care are not being delivered to the majority of patients because the patients are entering the system too late and are not taking advantage of prodromal symptoms. Chest discomfort must be promoted as a risk factor and emergency room programs developed whereby patients can be checked out and treated early.

Although heart attack is the nation's number one health problem, it may be possible to topple it from this lofty position in the future. Miraculous achievements have taken place in medicine in the past—witness the invention of the pacemaker. Twenty-five years ago, patients were painfully stimulated from an external source in order to stay alive, and suicide was not uncommon. Today, such patients can be treated with permanent pacemakers, be out of the hospital within several days, and receive follow-up via a telephone call. The pacemaker's life is about 10 years; when there is difficulty, programming can take place externally over the chest wall, preventing re-operation.

The secret to achieving success has to do with the learning curve. The process of learning takes place over time. Progress begets progress. Perhaps what is most important is to have a cornerstone that gets one on the path of that learning curve. Once that is accomplished, creative steps can be taken to overcome seeming resistance points, because available energy will be focused on the problem. The cornerstone then takes on a new value. It not only gets one started but opens the door for even more advances. Witness what has taken place in coronary care units over the last 25 years.^{1,2}

Before 1960, there was little physicians could do for heart attacks. Patients were kept in oxygen tents, given morphine for pain, and provided oxygen for shortness of breath. The development of cardiopulmonary resuscitation (CPR) and Hughes Day's application of this technique to the heart attack problem started the first coronary care unit. CPR was the cornerstone that got clinicians started on that learning curve. As a result, nearly every hospital in the United States now has a coronary care unit. These coronary care units have become the research benches for progressive discoveries. Drugs are now available to immediately dissolve occlusive blood clots, thus preventing heart damage. Studies have shown that the final event leading to a heart attack is a clot superimposed upon an atherosclerotic plaque. Through angiography, M. A. DeWood, M.D. has been able to show that 85 percent of heart attack patients exhibit such

*Presented May 1991 at the 193rd Annual Scientific Session of the Maryland Medical and Chirurgical Faculty—*American Medicine Today: Perspectives from Maryland*.

clots.³ In addition, when complete occlusion occurs, there is a wave front of cell death over time; if therapy is started early enough to open such vessels, the amount of damage can be minimized. As a result, mortality has been reduced in coronary care units from 30 percent to 5 percent, and perhaps even less.

Thus, thrombolytic therapy has made the management of acute myocardial infarction (MI) very promising. Studies have further shown that it is safe to give thrombolytic therapy in community hospitals. In over 200 cases using streptokinase at St. Agnes Hospital, mortality was 7 percent at discharge and 7 percent over the next five years with a complication rate of less than 1 percent. Furthermore, once thrombolytic therapy is given in a community hospital, it is not necessary to immediately rush the patient to a tertiary facility for catheterization. The recent TIMI-II B study⁴ has shown that it is not even necessary to proceed to cardiac catheterization in all patients receiving thrombolytic therapy; patients can be managed medically unless there is evidence of ongoing ischemia manifested by postinfarction angina or by a positive stress test done prior to discharge or six weeks after. If no such ischemia exists, patients managed medically have the same mortality rate as those treated aggressively with catheterization and subsequent percutaneous transluminal coronary angioplasty (PTCA) or coronary artery bypass graft (CABG). Thus, the community hospital has become a very important center for the management of the heart attack patient.

Unfortunately, not all MI patients receive thrombolytic therapy. Currently, only patients who present with ST elevations within the first six hours receive thrombolytic therapy. This amounts to about 25 percent of all MI patients. The major beneficial results, however, take place when patients are given thrombolytic therapy within the first hour of admission to the emergency room; only 10 percent of the patients in the GISSI-I study were in that group.⁵ At St. Agnes Hospital, 20 percent of the patients are in that group because of a prioritized game plan in the chest pain emergency room for heart attack patients. Delay in prehospital time appears to be the major reason for most late thrombolytic treatment. Thus, enthusiasm for this type of early cardiac care needs to be balanced by the fact that it can be applied only to a small number of heart attack patients (20 percent) and, of these, only 10 percent within the golden first hour. Therefore, a better link is needed between the community and the hospital that would reduce delay in therapy, as well as expand the capability of treating patients other than those with ST elevations (Figure 1).

Focusing on the ideal patient for thrombolytic therapy (first-hour MI patient) has, to date, been elusive. It might be compared to the golden fleece of Greek mythology—something almost impossible to capture. Presently, we are awaiting for the total occlusion of the

coronary vessel to take place and then expect rapid transport for thrombolytic therapy to be effective. The question comes up—is it possible to be involved earlier, before the occlusive event? Not only would this be an excellent strategic step, but the first-hour MI patients would be coupled with patients who do not yet have completely blocked vessels, and thus have no damage (Figure 2). Thus, a larger number of patients would be treated, and not just those with ST elevations.

Not all heart attack patients present with chest pain, and of those who do present with chest pain, not all have symptoms that would lend themselves to management at this crucial stage. However, a significant number do have chest pain and a significant number of those with chest pain do have early warning signs (stuttering chest discomfort) long before total occlusion takes place. Denial of such symptoms is common when they are mild. In a recent *JAMA* article, the author raises the question, "Is the ischemia silent or is the patient silent?"⁶ There are numerous studies that describe 40–60 percent of heart attack patients having prodromal symptoms for hours, days, or weeks prior to coming to the hospital with total occlusion (Figure 3). Thus, the best form of early cardiac care may not be thrombolytic therapy but cardioprotective

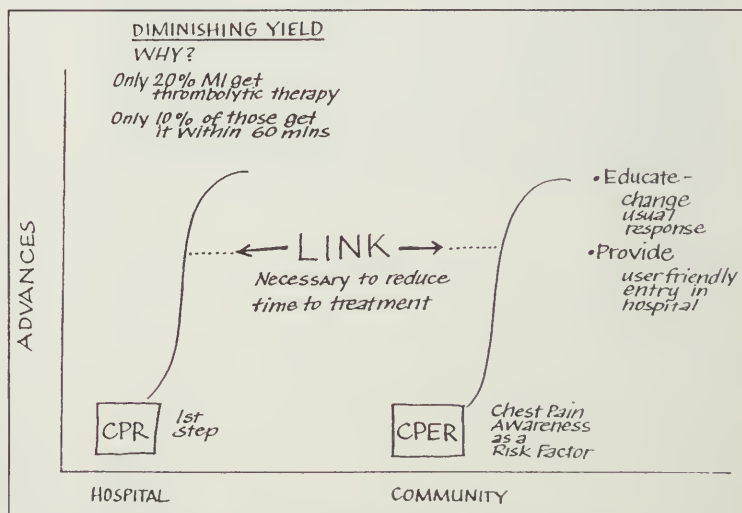


Figure 1. Improving the link between the community and the hospital can reduce delay in therapy.

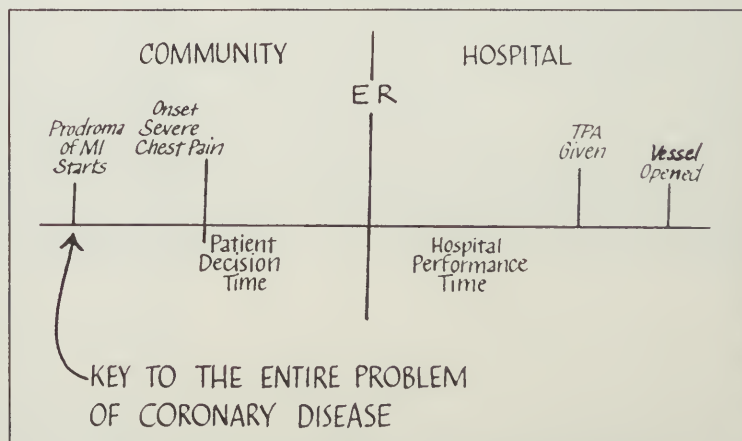


Figure 2. Involvement before the occlusive event is crucial.

therapy when prodromal symptoms are present (Figure 4). Not only does cardioprotective therapy address the disease when more benefits are available to the patient, but it also

offers therapy to many more patients than can be treated with thrombolytic therapy alone. The real question is whether prodromal symptoms can be identified, recognized, and acted upon in the community hospital.

Twenty years of rounds in coronary care units have convinced me that these prodromal symptoms are real and are not a fluke.⁷ However, once when a patient did come in early, a nurse asked him, "What possessed you to come in early?" as if it were unnatural to do so. Perhaps the delay in seeking treatment is due to the tremendous resistance and rationalization that take place early, when symptoms are minimal. It is only when severe pain occurs or a "Mack truck" is sitting on the chest, that patients feel they need to call 911 or be seen in the hospital. Unfortunately, this is probably one of the reasons why heart disease remains our number one health problem—we just don't act early enough.

With all this knowledge, one would think that chest pain or the delay in seeking attention when chest pain starts would be included with other risk factors such as cigarette smoking, hypertension, and cholesterol. National awareness programs exist for all of those risk factors, but not for chest pain. Yet, when meaningful chest discomfort does start, a patient is more at risk for sudden death than by having an elevated cholesterol level or a history of cigarette smoking. When a heart attack does take place, it is not what got the patient to that point that is important, but what is done once the cardiac symptoms start to manifest themselves. Thus, the more important risk factor or final risk factor is chest pain or the chest discomfort syndromes.

Chest pain may not always be very painful or strangulating. Early on, it may exist as a mild discomfort, centrally located, that comes on with activity and is relieved by rest (stuttering); it is easily put off because symptoms are mild. It is difficult to talk such patients into having these symptoms checked-out, especially when the patient has many things to do. Yet it's necessary if we are to have an impact on this major health problem.

Chest pain appreciation is needed to get us on a learning curve for community activation. Once we start on this learning curve, progress will beget progress and we will develop creative ways to deal with obvious problems, such as gridlock and saturation in the emergency medical system and emergency rooms. It will become increasingly important to have a place within the hospital to check-out patients with early symptoms and to establish a community outreach program that can help promote this effort (i.e., early cardiac care centers).^{8,9}

The question may arise whether such a private sector effort of early cardiac care centers can be started in all American communities. Is there a precedent? Yes—coronary care units did not always exist. They began in the late 1960s. Once it made sense to have such a unit, many hospitals started them up. When a critical number

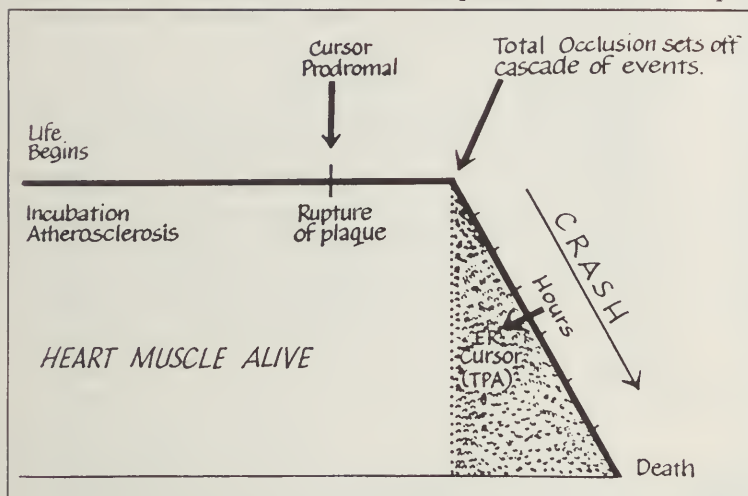


Figure 3. Many patients have prodromal symptoms long before coming to the hospital with total occlusion.

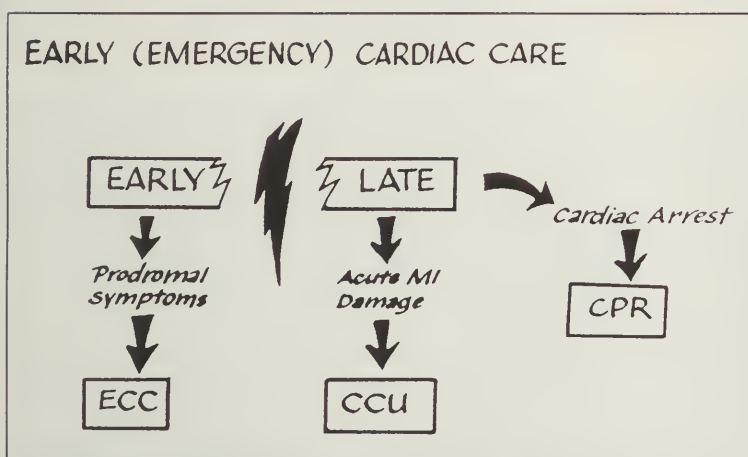


Figure 4. When prodromal symptoms are present, cardioprotective therapy may be more important than thrombolytic therapy.

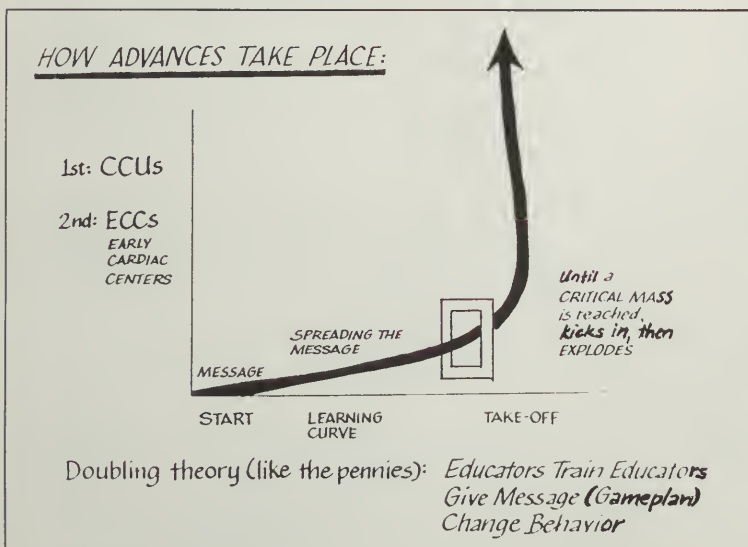


Figure 5. As an idea catches on, growth increases dramatically.

of coronary care units were reached (approximately 250), exponential growth took place whereby virtually every hospital in the United States during the ensuing years developed a coronary care unit (Figure 5). The concept of early cardiac care centers or chest pain emergency rooms may do likewise. Thus far, there are 124 chest pain emergency rooms in 35 states—an increase of 21 and two, respectively, in just the past two months. Another 70 hospitals have expressed interest in starting such units. The Health Care Advisory Board in Washington, DC has recommended the chest pain emergency room concept to its 500 members as a major strategic step in cardiology for the 1990s. It makes sense to do this for many reasons, but most importantly, it represents a private sector effort in the fight against heart disease.

The community hospital has become a key in this success

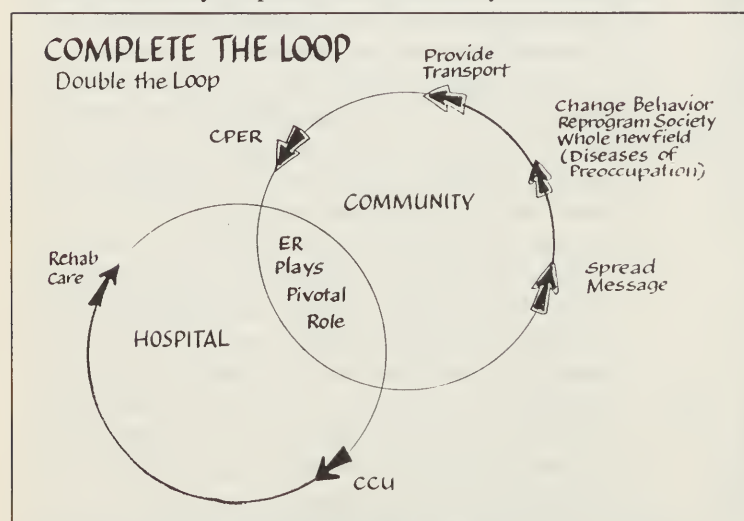


Figure 6. Increasing patient awareness of chest pain as a risk factor can enhance the delivery of care.

story. Not only is it recognized that thrombolytic therapy and cardioprotective therapy are best accomplished at this level, but patients do not have to be rushed to tertiary care centers unless ongoing ischemia is present. However, the real problem involves the delivery system and how to expand it to include all patients. Coronary care units grew rapidly when common sense prevailed, long before scientific data were available to show the units' worth. The value-added aspect of CPR in getting these units started cannot be underestimated. So too, promoting chest pain as a risk factor through a national awareness program similar to those conducted for other major risk factors, would get us started on bringing about a community game plan designed to enhance the delivery phase (Figure 6). To date, this has not taken place because the Public Health Service and the National Heart,

Lung and Blood Institute have been concerned about possible problems with this approach. However, there is now a consensus for a National Heart Attack Alert Program scheduled to have begun in the summer of 1991.¹⁰

The problem with this approach is that it focuses primarily on the professional. Only years later, when the scientific database is developed, will the information get to the public. This process is very slow, entailing endless consensus conferences and agreements—paralysis by analysis. A more rapid approach would have community hospitals pushing for early public involvement in increasing awareness that heart attacks have beginnings (prodromal symptoms) and that early intervention amounts to prevention of sudden death and damage to the myocardium (Table).

The heart attack problem has been the number one killer of the adult population since the turn of the cen-

Table. Awareness programs for the heart attack problem

	NIH (NHLBI)	The Early Cardiac Care Program (St. Agnes)
1. Program	National Heart Attack Alert Program (NHAAP)	National Chest Pain Awareness Program
2. Emphasis	Emphasis is on detecting heart attack early so as to reduce delay outside the hospital. Get heart attack victims into the system quickly.	Emphasis is on early detection out in the community through increased recognition of anginal equivalents and prodromal symptoms. Reawakening awareness.
3. Present focus	Initially, focus is on the professionals, with a heightened awareness for the problem of time delay.	Focus is primarily on the public, including the educational system, community leaders, hospital administrators, ER physicians, and cardiologists
4. Behavioral changes	When victims are experiencing heart attack symptoms, there should be an all out effort to get the victim quickly into the system.	Change behavior when heart attacks are beginning. It is important to understand the reasons for delay and to resolve them. There is an effort to understand the dynamics of the beginning heart attack. Plans can be worked out to correct the public's misconceptions.
5. Action	Call 911 and the emergency medical system. (Emergency rooms, unfortunately, are not all created equal, and display a mixture of responses to such incoming patients.)	Make a real effort to provide user-friendly reception for those who come in with minimal symptoms, so as to create a sliding effect into the hospital for these early patients.
6. Gameplan	Same as awareness programs for cigarette smoking, cholesterol, hypertension, etc.	Anticipate rapid growth as demonstrated by the exponential growth of CCUs. Use the power of "an idea whose time has come." When a critical number are achieved, see if there is an explosion in the number of units nationwide.
7. Primary goals of therapy	Thrombolysis: ASA, thrombolytic agents, heparin.	Cardioprotection: ASA, beta and calcium blockers, nitrates, heparin, xylocaine.

ture. No one can remember it ever being out of first place. Heart attack can be removed from its number one position before the year 2000 if widespread community hospital participation can be recruited.¹¹⁻¹³

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Acknowledgments

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Access to early cardiac care: A commentary

In this issue of the *Maryland Medical Journal*, Dr. Raymond Bahr discusses the need for early recognition and treatment of acute myocardial infarction. These goals cannot be overemphasized. Fully one-third of the mortality associated with acute myocardial infarction occurs before patients reach medical assistance. Minimizing this unsafe period would do much to decrease this untoward outcome. In the past decade, intravenous administration of thrombolytics has been shown to reduce the mortality of acute myocardial infarction further. In those studies in which thrombolytic agents have been administered within one hour, residual ventricular function remains almost normal. Unfortunately, many patients experiencing chest pain wait hours before seeking medical advice, if they do so at all. Clearly, a greater educational effort must be extended to the general public, as well as to patients with significant likelihood of developing acute infarction.

Dr. Bahr correctly identifies the community hospital as the site at which patients with chest pain usually seek medical care. It is imperative that such patients have prompt evaluation and consideration of thrombolytic therapy. At the present time, patients wait an average of one hour after reaching an emergency department before treatment with thrombolytic agents is instituted. Emergency departments must be organized so as to evaluate patients with chest pain promptly and institute treatment rapidly. Practices such as 30-minute delays following the administration of nitroglycerine to determine whether chest pain will be totally relieved must be eliminated. Emergency rooms must be staffed by physicians capable of interpreting early electrocardiographic changes. Whereas computer-

ized electrocardiography is approximately 75 percent sensitive to the detection of early myocardial infarction, careful physician assessment approaches 100 percent sensitivity. Prompt echocardiographic evaluation of left ventricular function can often identify the presence of acute infarction even when the electrocardiogram is nondiagnostic.

Taking the concept of early diagnosis and treatment a step further, many cities are now experimenting with emergency technician diagnosis of acute infarction and administration of thrombolytic agents. Most experiences with this earliest form of treatment have been positive. This practice is likely to gain wide acceptance in the next decade. Clearly, in-field administration of therapy provides the earliest possible benefit from thrombolysis and maximal recovery of affected myocardium.

Lastly, Dr. Bahr correctly states that only 20-25 percent of patients with acute myocardial infarction receive thrombolytic therapy. Many of these patients are not good candidates for thrombolytic therapy because of potential bleeding situations. These patients should be promptly considered for primary angioplasty performed in tertiary care institutions. Thus, access to early care in the future means earlier patient recognition, widening in-field diagnosis and treatment, prompt management in emergency departments, and consideration of a broad spectrum of therapeutic options.

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The relationship of maternal race and insurance status to prenatal ultrasound use in a national population

Ronald G. Kaczmarek, M.D., M.P.H.;
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Data from the first group of respondents (N=4,846) of the 1988 National Maternal and Infant Health Survey were analyzed. After controlling for potentially confounding factors, such as maternal age, in a multivariate analysis, no relationship could be demonstrated between insurance status or race and the probability of receiving a prenatal ultrasound examination.

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Ultrasound examination can be an important component of prenatal care. This examination can be performed for a variety of indications, including establishing gestational age, determining fetal position, confirming the presence of fetal life, locating the placenta, assessing fetal growth, and determining the existence of multiple pregnancy.¹

Despite the absence of official recommendations from such groups as the American College of Obstetricians and Gynecologists, many obstetricians believe that each pregnancy should have at least one ultrasound examination to ensure that progress is satisfactory.²

The health insurance coverage of pregnant women varies widely. Three tiers of insurance may be identified: private, Medicaid, and none. Private insurance may be fee-for-service or prepaid health insurance. Health maintenance organizations, such as Kaiser Permanente, are examples of prepaid health insurance. Less affluent Americans may receive Medicaid benefits. An estimated 37 million Americans lack any health insurance.³

Studies have suggested that insurance status and race may be related to access to medical procedures. For example, a study noted that insured lung cancer patients who did not have surgery were significantly more likely to receive chemotherapy or radiation therapy than uninsured patients.⁴ Another study noted racial inequality in access to renal transplants.⁵ However, a study by Moore et al of access to prenatal ultrasound in a large, urban, teaching hospital found that uninsured and African-American patients were actually more likely than privately insured patients to receive prenatal ultrasound examinations.⁶

The purpose of this study was to examine the relationship between factors such as insurance status and race, and the performance of a prenatal ultrasound examination in a national population in order to replicate (or not) the results reported by Moore et al.⁶ A secondary purpose was to find independent apparent predictors of prenatal ultrasound use.

Methods

The 1988 National Maternal and Infant Health Survey (NMIHS)⁷ is a nationally representative survey designed to study factors related to adverse pregnancy outcomes, such as fetal loss, prematurity, and low birthweight. The NMIHS, conducted by the National Center for Health Statistics (NCHS), was cosponsored by a number of federal agencies, including the Center for Devices and Radiological Health (CDRH), a unit within the Food and Drug Administration.

The target sample size of the complete NMIHS was 20,000 fetal deaths, live births, and infant deaths. The design included oversampling of African-Americans, American Indians, low-birthweight infants, very low birthweight infants, and infant deaths. Signed consent statements were obtained from the voluntarily participating mothers to request the release of data from their medical records and the medical records of their infants. The mothers, hospitals, and prenatal care providers contributed information through mail questionnaires, or if necessary, by telephone or personal interviews with interviewers from the Bureau of the Census. Mothers provided demographic data, a clinical history for previous pregnancies, names of prenatal care providers, payment sources, and some clinical information about prenatal care. Providers and the delivery hospital answered more specific questions about clinical care.

The study participants were obtained from the first group of respondents to the 1988 NMIHS (N=4,846). The sample was not randomly selected and therefore may not be nationally representative, but included a broad spectrum of mothers, providers, and institutions.

Survey responses were used to construct summary variables. The outcome variable (ever had an ultrasound examination during this pregnancy) was summarized from all three sources into three levels: (1) yes—provider or hospital indicated an ultrasound examination or gave gestational age at delivery as determined by ultrasound examination, (2) no—provider and hospital did not indicate there was an ultrasound examination, and at least one source said there was no ultrasound examination, and (3) unknown—mother answered ultrasound question (no distinction between Doppler and ultrasound examination) as no or unknown, and provider and hospital indicated ultrasound examination status unknown. Similar strategies were used to summarize some of the independent clinical variables:

- previous miscarriage or preterm delivery (any of last eight pregnancies ended in miscarriage or delivery before 37-weeks gestation);
- possible multiple fetuses (based on fertility hormones or injections, and actual pregnancy outcome);
- potential miscarriage (cramps or bleeding); as well as
- a variable to indicate whether the mother's household received government income in the form of Aid to Families with Dependent Children, public assistance, welfare, food stamps, housing assistance, public housing, Social Security income, or unemployment insurance.

Other variables were derived to indicate

- fetal death (vs live birth)
- low birthweight (<2.5 kg)
- very low birthweight (<1.5 kg)
- mother is of African-American heritage
- mother is of white race
- mother's marital status
- maternal age
- mother's education
- father's education
- mother's household income
- primary prenatal care provider type
- prenatal care payment sources (according to mother)
- mother received treatment for blocked fallopian tubes
- mother was active smoker during the 12 months before delivery
- other people smoked in mother's household (passive-smoking history)
- mother gained less than 9 kg during pregnancy
- gestational time of first prenatal visit
- gestational time of second prenatal visit

Analysis was begun with univariate cross tabulations and logistic regression models using the ultrasound examination summary variable and each independent indicator variable. In each logistic regression model, the only contributing subjects were those for whom values were known for all variables in that particular model. Therefore, the contributing number of subjects varied from model to model. Variables for which coefficients exhibited statistical significance (which included all clinically meaningful associations) were combined in multivariate models; those variables that continued to manifest statistical significance were interpreted as being independently associated with prenatal ultrasound examination use and were used to derive the final model for all subjects. Lastly, the final model was applied separately to the live birth and fetal death subsets. For all univariate and final results, odds ratios (OR) and their 95 percent confidence limits (CL) were derived from the logistic regression estimates of the parameter values and standard errors.⁸

Results

Out of the total sample, 79 percent of the 2,633 mothers with known status had had at least one ultrasound examination. Simple, univariate analysis showed that African-American maternity was strongly inversely related to prenatal ultrasound examination (Table 1). In addition, insured mothers and those with military or Indian Health Service sources of payment were more likely to have had ultrasound, while mothers dependent on Medicaid or other government assistance were less likely to have had ultrasound. Table 2 summarizes the results of univariate analysis for other demographic, health care, and clinical characteristics.

When multivariate modeling was used to discover the characteristics that were consistently and independently asso-

ciated with prenatal ultrasound (Table 3), three variables were predictive; maternal age ≥ 35 , prior miscarriage or premature birth, and fetal death. None of the other variables, including race, insurance status, and provider type, were independently associated with prenatal ultrasound use. Although this model was based on fewer subjects (1,209 with known data for all model variables), the proportion who had an ultrasound examination (80 percent) remained unchanged. Cross tabulations of the model variables with maternal race revealed that in the study population, African-American

Table 1. Association of racial and insurance status with prenatal ultrasound examination.*

Variable	Odds ratio	95% confidence limit
Mother is an African-American	0.19	(0.10, 0.34)
Insurance	1.62	(1.47, 1.79)
Military or Indian Health Service	1.51	(1.01, 2.26)
Mother or her family	1.05	(0.95, 1.16)
Medicaid or other government assistance	0.79	(0.71, 0.87)
Other	0.71	(0.54, 0.94)

*Results derived from univariate models.

Table 2. Summary of associations of demographic, health care, and clinical characteristics with prenatal ultrasound examination.*

Exam was more likely ($p < 0.05$) if:

- household income $\geq \$20,000$.
- prenatal care provider was a clinic in a hospital.
- the mother was married.
- either parent had finished high school.
- maternal age ≥ 35 .
- pregnancy ended in fetal death.
- there had been prior miscarriage or premature birth.
- the mother was treated for blocked fallopian tubes.
- the mother had cramps or bleeding.
- there was a possible multiple pregnancy.

Exam was less likely ($p < 0.05$) if:

- the mother did not finish high school.
- household income $\leq \$7,000$.
- the household had government income.
- maternal age < 20 .
- the prenatal care provider was:
 - county or city health department.
 - health maintenance organization.
 - clinic at work or school.

Exam was not associated ($p > 0.05$) with:

- low or very low birthweight.
- passive or active smoking.
- < 9 kg weight gain.
- the timing of first and second prenatal visits.

*Results derived from univariate models.

Table 3. Prediction of prenatal ultrasound examination

Independent variable in model	Odds ratio	95% confidence limit
Maternal age ≥ 35	1.86	(1.37, 2.51)
Prior miscarriage or premature birth	1.40	(1.21, 1.61)
Pregnancy ended in fetal death	2.36	(1.97, 2.82)

mothers were just as likely as white mothers to be 35 years old or older, but less likely to have had a fetal death end the current pregnancy, or have had a previous miscarriage or a preterm delivery.

When the final model was applied to the subsets of 837 live births and 372 fetal deaths, the estimates for previous miscarriage or preterm delivery were of similar magnitude for the whole and both parts (OR = 1.39, 95 percent CL = 1.18, 1.64 for live births, and OR = 1.45, not statistically significant for fetal deaths). Maternal age ≥ 35 became even more important (OR = 2.98, 95 percent CL = 2.00, 4.45) for live births, and was inversely related for fetal deaths (OR = 0.66, not statistically significant).

Discussion

Based on the crude data, African-Americans were less likely than whites to receive prenatal ultrasound examinations. However, after controlling for other variables, such as maternal age, race was not found to have an effect on receiving a prenatal ultrasound examination. In the study by Moore et al,⁶ there was no evidence that African-Americans were less likely than whites to receive prenatal ultrasound examinations. Studies have demonstrated the existence of racial inequality in access to some important medical procedures such as organ transplantation. African-Americans encounter significantly longer waiting periods than whites for renal and liver transplants.^{5,9}

The United States faces a chronic shortage of kidneys, livers, and other organs for transplantation. Consequently, organ transplantation is what economists term a zero-sum game—providing an organ transplant to one individual eliminates the availability of that organ for transplantation in a second individual. It is important to observe that a shortage of ultrasound equipment or trained personnel essential to the conduct of a prenatal ultrasound does not exist in the United States, so the provision of a prenatal ultrasound examination does not preclude a second patient from also receiving the examination. This may have contributed to the observed absence of racial inequality in access to prenatal ultrasound in the study population.

Analysis of the crude data from this study indicated that insurance status was related to the probability of receiving a prenatal ultrasound examination. Uninsured individuals were significantly less likely than insured individuals to receive prenatal ultrasound examinations. However, after controlling for confounders such as age and clinical presentation, no relationship could be detected between insurance status and prenatal ultrasound examinations.

Other studies of insurance status and medical procedures have described a relationship between insurance status and the probability of receiving a medical procedure. For example, Weissman and Epstein reported that uninsured hospitalized patients in the Boston, Massachusetts area underwent 7 percent fewer procedures than insured patients.¹⁰ A study of the relationship between insurance status and the utilization

of cardiac procedures reported that Medicaid patients had 48 percent lower odds of receiving angioplasty than privately insured patients.¹¹ A study by Hadley et al³ noted that five high-cost and/or discretionary procedures (coronary artery bypass surgery, total knee replacement, total hip replacement, stapedectomy, and surgical correction of strabismus) were performed significantly less often among the uninsured. However, the Hadley study also observed that based on insurance status, no significant difference in the performance of some other medical procedures was observed.

The Hadley study indicates that the degree of cost and discretionary nature of a medical procedure may be related to the effect of insurance on access to that procedure. This may help explain why no relationship between insurance status and prenatal ultrasound examinations was observed. The cost of a prenatal ultrasound examination is far lower than the cost of any of the five high-cost procedures included in the Hadley study. Prenatal ultrasound is being increasingly viewed as an essential, not discretionary, part of prenatal care, as illustrated by the very high prevalence of prenatal ultrasound in the study population.

Many health maintenance organizations utilize prepaid health insurance, which may provide financial incentives for foregoing medical procedures such as diagnostic tests. This is contrary to what one would expect under fee-for-service insurance plans, which may provide financial incentives to physicians for the performance of medical procedures and diagnostic tests in that the physicians' level of reimbursement will increase as more procedures are performed. In our study population, membership in a health maintenance organization was not related to the probability of receiving a prenatal ultrasound examination. It is conceivable that many health maintenance organizations might consider prenatal ultrasound to be of sufficient value and importance that its use would not be restricted by cost considerations.

Medicolegal considerations may have helped promote the use of prenatal ultrasound and overcome any obstacles posed by insurance status. Malpractice suits are a problem for all physicians, but obstetricians are sued more often and for larger awards than the average physician. Consequently, obstetricians may pay annual malpractice premiums in excess of \$100,000.¹² Conventional wisdom among physicians conveys the message that since malpractice suits arise from errors of omission, not commission, cost considerations for an uninsured or Medicaid patient are relatively minor.

In our study population, the prevalence of prenatal ultrasound examinations was remarkably stable until maternal age 35, when it suddenly increased. This pattern seems to reflect a perceived sudden, as opposed to gradual, increase in risk with advancing age. Older maternal age is a recognized risk factor for adverse pregnancy outcome, such as genetically based syndromes.¹³ Teenage pregnancy is another recognized risk factor for adverse pregnancy outcomes, such as low birthweight.¹⁴ The Moore et al study had also found that prenatal ultrasound examination was associated with ad-

vanced maternal age but not very young age.⁶ Further study may be warranted to understand the mechanism behind this pattern.

The history of a previous miscarriage or preterm delivery was associated with an increased probability of receiving a prenatal ultrasound examination. This association remained after multivariate analysis was performed to control for confounding factors. Providers may be more concerned about fetal well-being in mothers with a history of a previous miscarriage or preterm delivery and be more likely to perform a prenatal ultrasound examination.

Analysis of the crude data revealed that prenatal ultrasound was used significantly more often during pregnancies that ended in fetal deaths than during pregnancies that resulted in live births. This significant difference remained after the performance of multivariate analysis to control for confounding factors. This finding may be related to the use of prenatal ultrasound to detect fetal death, but we cannot confirm this from the presently available data.

There was a substantial prevalence of prenatal ultrasound use in the study population, approximately 80 percent. This high level of prenatal ultrasound is consistent with what was observed in the 1987 pretest of the NMIHS,¹ which indicated a prenatal ultrasound prevalence of 78.8 percent. The prevalence of prenatal ultrasound in the present and Moore studies is far greater than the 33.5 percent level that was reported in the 1980 National Natality Survey.¹⁵ Several factors may have contributed to the marked increase in prenatal ultrasound use. First, there has been a substantial increase in the number of trained personnel, including both technicians and physicians, capable of performing prenatal ultrasound examinations. Second, there has been a parallel increase in the supply of ultrasound equipment. Third, ultrasound is widely perceived as a safe examination because it does not entail the use of ionizing radiation. Fourth, the clinical applications of ultrasound have increased over the past decade.

An important caveat influencing the interpretation of this study is the nature of the study group. It represents instances in which the state cooperated by sending NCHS birth/vital records with the mother's name and address, the mother responded to the survey, and her prenatal care providers and hospital provided data. The extent to which these factors influence the generalizability of the results is unknown, although the sample apparently represents a broad spectrum of experience. Except for indicators of live births and fetal deaths, oversampling variables were used in the analysis and had no influence.

The major advantage of the present study compared with the original Moore study is that the eligibility criteria in the present study are far more inclusive. Mothers who delivered at virtually any of the health care facilities in more than 20 states were eligible for participation in the present study. In contrast, the original Moore study, although comprehensive in scope, was limited to one large, urban, teaching institution. Factors unique to that institution, that region, that size of

hospital, and the nature of that hospital (i.e., teaching hospital) may have influenced the results.

In conclusion, after controlling for potential confounders such as maternal age and clinical presentation, no relationship was observed between insurance status or race and the probability of receiving a prenatal ultrasound examination. Factors such as the perceived importance and limited cost of the examination, as well as medicolegal considerations, may have helped override any obstacles posed by lack of insurance. The high level of prenatal ultrasound use may reflect its increased availability and perceived importance, or the presence of risk factors for an adverse pregnancy outcome. Further study is warranted to determine the national prevalence of prenatal ultrasound use.

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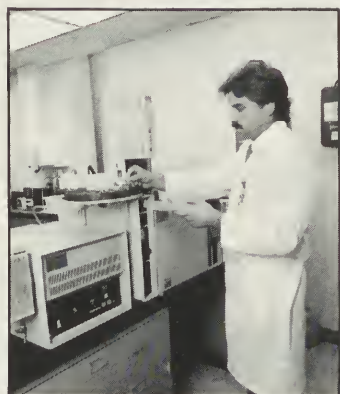
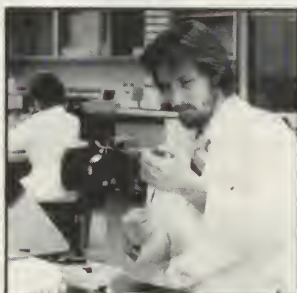
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THE MARK OF EXCELLENCE

Thalassemia screening in Baltimore

Allen D. Schwartz, M.D. and Ruth E. Luddy, M.D.

From Sinai Hospital of Baltimore where Dr. Schwartz is chairman, Department of Pediatrics and Dr. Luddy is associate attending, Department of Pediatrics. Reprints: Allen D. Schwartz, M.D., Sinai Hospital of Baltimore, Belvedere at Greenspring, Baltimore, MD 21215.

An education and screening program for β -thalassemia was offered to members of the Greek and Italian communities in the Baltimore area to allow for educated decisions regarding childbearing. Similar programs have been effective in decreasing the incidence of β -thalassemia major in other countries.

In 1925, Thomas B. Cooley and Pearl Lee described five children in Detroit with severe anemia and unusual red cell morphology. The children also had hepatosplenomegaly, a peculiar appearance caused by enlargement of the cranial and facial bones, and abnormal long bones.¹ These two pediatricians are now credited with separating a newly recognized disorder from a conglomerate of childhood infectious and malignant diseases. Over the following years, it became apparent that Cooley's anemia occurred predominantly in individuals of Mediterranean heritage, and the term *thalassemia*, taken from Greek words meaning "sea in the blood," was coined to associate the disease with the Mediterranean Sea.²

In both the United States and Italy, a mild microcytic anemia was later described that was called familial microcytosis. By the early 1940s, it was established that both parents of children with Cooley's anemia had this finding and that thalassemia, in the heterozygous state, resulted in thalassemia minor or trait. Those affected often might go unnoticed or be misdiagnosed as having mild iron deficiency. In the homozygous state, however, thalassemia caused the severe and often fatal thalassemia major described by Cooley and Lee.³ Although individuals with thalassemia minor are healthy and live normal lives, the genetic implications should be of great concern to those affected.

Education and screening programs for β -thalassemia trait, a defect in β -chain production of the hemoglobin molecule, have been conducted in a number of countries throughout the world, including high-risk communities in the United States, Britain, Italy, Greece, and Cyprus.⁴⁻⁹ In Maryland, there are tens of thousands of citizens of Mediterranean origin, and a large number of people in the Greek and Italian communities with β -thalassemia minor remain unrecognized. In the late 1970s, a program was begun in the greater Baltimore area and other parts of Maryland to screen individuals of Mediterranean heritage. The program was discontinued in the mid-1980s since the Thalassemia Committee of Greater Baltimore was concerned about the possibilities of litigation, because

insurance coverage of the blood-drawing team was unclear. The purpose of this communication is to make the physicians of Maryland aware of how common thalassemia minor is in Baltimore, especially in certain ethnic communities, and to describe a simple method of screening to differentiate it from iron deficiency anemia. (As we had no idea of the actual incidence of thalassemia in Baltimore, we have not conducted a follow-up to look for changes.)

Methods

A comprehensive screening program was offered to members of the Greek and Italian communities of Baltimore, Annapolis, and surrounding areas. The majority of the Greek community was offered the program through their churches; the Italian community was screened through one church in Baltimore and various chapters of the Order of the Sons of Italy. A small number of individuals who had heard of the screening were self-referred for testing.

Prior to any testing, educational programs involving lectures, question and answer sessions, and distribution of literature were offered to the target population at risk. In most instances, the blood drawing was done at least one week following these programs to allow those who did not wish to be tested to gracefully avoid the program, and those who wished to bring family members to the screening, the opportunity to do so.

After signed consent was obtained, 4.5 cc of venous blood was drawn into sodium edetate (Versene) anticoagulant. Anticoagulated blood was screened with the Model S Coulter electronic counter; this counter directly measures red-cell count, hemoglobin, and mean corpuscular volume (MCV). Based on previously reported studies, microcytosis in adults was defined as an MCV of less than $79\mu^3$. In the small numbers of preadolescents screened, normal MCV levels were defined as previously reported in the literature.¹⁰ Cellulose acetate hemoglobin electrophoresis was done on every specimen. All patients with microcytosis had quantitation of hemoglobin A₂ and F to detect β -thalassemia trait, and had free erythrocyte protoporphyrin (FEP) levels measured on whole blood and red blood cells to indicate the presence of iron deficiency. The hemoglobin A₂ levels were done by column chromatography. These levels were not determined on individuals with a normal MCV. All laboratory testing was performed by the laboratories of the Maryland Department of Health and Mental Hygiene. Results, printed in English, Greek, and Italian, were sent to all individuals tested. Those with unexpected serious findings were notified by mail and phone to insure medical follow-up. Those with thalassemia trait and other hemoglobinopathies were offered genetic counseling services. Approval for the study was obtained from the University of Maryland Hospital's Human Volunteers Research Committee.

Results

A total of 1,527 individuals were screened. Of these, 1,356 had normal MCV determinations. Within this group,

there were two unrelated individuals with Hgb AC (hemoglobin C trait), and four with Hgb AS (sickle cell trait)—two of whom were related (mother and son). These six were counseled accordingly. One elderly male was found to have a markedly elevated white cell count, and had previously been diagnosed as having chronic lymphocytic leukemia. One man with a history of small bowel resection had a hematocrit of 28 percent and an elevated MCV of $116\mu^3$. He was referred to his physician to be evaluated, and was found to have vitamin B₁₂ deficiency.

One hundred seventy individuals were found to have a low MCV. Of these, 126 (8 percent of the total population screened) had elevated levels of Hgb A₂ and/or Hgb F, and were diagnosed as having β -thalassemia trait. Individuals with β - δ -thalassemia have microcytosis and elevated Hgb F, but normal Hgb A₂ levels; this has the same genetic implications as β -thalassemia trait.

Eight individuals had microcytosis, normal Hgb A₂ and F levels, and elevated FEP levels. They were diagnosed as having iron deficiency anemia. Seven were women in their childbearing years, and one was a man with a recent history of surgery with significant blood loss. All were, therefore, already at risk or had a good explanation for iron deficiency anemia.

Thirty-six people had microcytosis, but no evidence of β -thalassemia or iron deficiency. A number of these subjects had the same last name and belonged to the same church or organization, suggesting that they were related. No attempt, however, was made to accurately document relationships. These individuals were believed to have α -thalassemia minor, a mild disorder in which there is a decrease in production of α -chains of the hemoglobin molecule, but one that does not have the same clinical significance in this particular population as does β -thalassemia minor.

Table 1 shows the results of the study, separating participants by country of origin. Mild microcytosis attributed to the presence of β -thalassemia trait was a more common finding in the Greek population (10 percent) than in the Italian population (5.1 percent). This difference was statistically significant ($p < .005$ by chi-square analysis). Results from three Greek churches in Baltimore were culled from the data, because over 50 percent of the participants (831 of 1,527) were from these churches. These data are shown in Table 2.

Table 1. Results of thalassemia screening in greater Baltimore and Annapolis areas

Nationality	Total	Normal MCV		Low MCV		
		Normal	Abnormal	β -thal. minor	Iron Defic.	α -thal. minor
Greek	1,004	858	6*	101 (10%)	6	33 (3.2%)
Italian	523	491	2**	25 (5.1%)	2	3 (0.5%)
Total	1,527	1,349 (88%)	8	126 (8%)	8	36 (2%)

* 4 Hgb AS, 1 chronic lymphocytic leukemia, 1 pernicious anemia

** 2 Hgb AC

Table 2. Thalassemia screening results in three Baltimore churches

Church	Total	Normal MCV		Low MCV		
		Normal	Abnormal	β -thal. minor	Iron Defic.	α -thal. minor
St. Nicholas	131	97	0	30 (23%)	1	3 (2.3%)
St. Demitrios	249	209	0	29 (12%)	3	8 (3.2%)
Annunciation Cathedral	451	389	3*	39 (9%)	1	19 (4.2%)
Total	831	695	3	98 (12%)	5	30 (3.6%)

* 3 Hgb AS

Discussion

Electronic measurement of the MCV of the erythrocyte is a reliable, rapid, and inexpensive method for screening for microcytosis. The more expensive and time-consuming screening tests need only be used to subcategorize those with microcytic indices into iron-deficiency anemia patients or those with α - or β -thalassemia minor. In this high-risk population, over 88 percent of the patients had no microcytosis and required no further workup. This screen, however, is not 100 percent effective, nor are any screening tests, in detecting the so-called silent carrier of β -thalassemia,^{11,12} which can only be detected by methods too complex for screening large populations. Fortunately, the prevalence of this silent carrier state for thalassemia is believed to be very uncommon.

This screening program documented a prevalence of 5 percent of β -thalassemia trait in those of Italian heritage. Population surveys in Italy show a remarkable heterogeneity in prevalence, ranging from 0.5 to 2 percent in certain northern and central regions of the country to as high as 27–30 percent in southern Sardinia.¹³ Our findings in screening a population representing diverse regions in Italy should not be unexpected.

A 10 percent prevalence of β -thalassemia minor was found in the Greek community. When the data obtained from the three Greek churches in Baltimore were evaluated separately, 98 of 831 subjects tested were positive, giving a prevalence of 12 percent (Table 2). The highest prevalence, found in those screened at St. Nicholas Church, was 23 percent. As in Italy, the distribution of the β -thalassemia gene in Greece is uneven, with gene frequencies ranging from under 5 to over 20 percent. The majority of the congregation of St. Nicholas Church comes from a number of islands of the Aegean Sea, with a large number from the island of Rhodes. Thalassemia is widespread among the island populations, with certain areas of Rhodes reported to have a prevalence as high as 25 percent.¹³ Members of the remaining churches trace their ancestry to areas of the mainland where the prevalence in different sections ranges from 5 to 15 percent. The high prevalence of β -thalassemia minor detected in Baltimore's Greek community is very likely due to the fact that those with a history of anemia or a family history of thalassemia were more likely to seek screening, resulting in a falsely elevated percentage of those affected. A second plausible explanation

for our findings, however, is that the prevalence of β -thalassemia minor in these Greek and Italian communities approximates that documented in the areas of origin of the subjects tested.

Thalassemia major is a very serious illness that usually requires intensive transfusion and chelation therapy. Persons with β -thalassemia minor, although healthy, are often thought to have iron deficiency and are treated with medicinal iron, a situation which has been known to lead to hemosiderosis.¹⁴ Mass-screening programs for β -thalassemia trait have already been shown to be effective, and have resulted in a fall in the birthrate of individuals with β -thalassemia major in a number of areas of the world.^{6,9,15,16} A strong case can therefore be made for screening and education programs in populations with a high prevalence of β -thalassemia trait, such as are found in Maryland.

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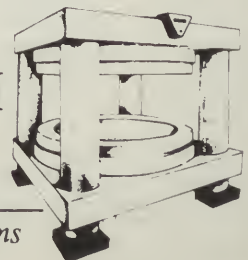
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Merkel cell carcinoma of the eyelid: A report of two new cases and a review of the literature

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Merkel cell carcinoma is a cutaneous neoplasm that rarely occurs in the eyelid. The tumor has an aggressive nature with high local recurrence and metastases rates. Early diagnosis and prompt complete excision with frozen section monitoring of margins are recommended.

The Merkel cell is a specialized cell of the basal epidermis that is presumably of neuroectodermal or neural crest origin.¹ The Merkel cell functions as a slowly adapting mechanoreceptor that perceives mechanical stimuli including touch and hair movement.² Recently, cutaneous neoplasms of Merkel cell differentiation have been reported.³⁻⁶ Although origination in the ocular tissues is rare, a few cases involving the eyelid have occurred.⁷⁻⁸ To our knowledge, only 11 isolated cases of Merkel cell carcinoma of the eyelid have been reported in the ophthalmic literature.

We present herein a histopathologic study of two new cases of eyelid Merkel cell carcinoma and a clinicopathologic summary of the reported cases. Immunohistochemical and ultrastructural analyses were also performed to further distinguish this rare lid tumor.

Report of cases

Case one. A 74-year-old man underwent excision of a growing nodule of the right upper eyelid. Examination disclosed an ill-defined bosselated and gray-tan region measuring 1.0 x 0.6 cm in the upper lid. A biopsy of the lesion was performed and led to the diagnosis of Merkel cell tumor. A total excision with frozen section monitoring of the surgical margins was subsequently performed (**Figure 1**). A Cutler-Beard procedure was utilized for reconstruction of the upper lid. Systemic evaluation, including computed tomography (CT) scan of the chest and abdomen, was normal. Four months later, the patient noted a mass in the right jugulodigastric region. Biopsy of this lesion revealed Merkel cell tumor consistent with the primary. One month later, the patient presented with an 8 mm small mobile lymph node in the same region. CT scan revealed no appreciable adenopathy. The patient underwent local radiation therapy. Eleven months after completion of radiation therapy, there was no evidence of local recurrence.

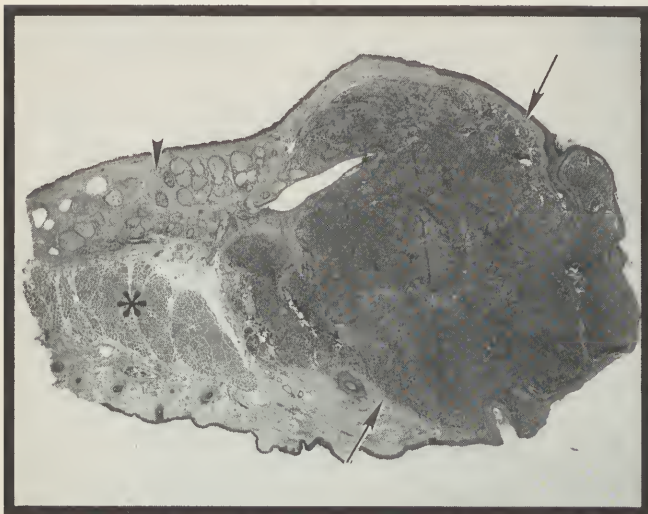


Figure 1. (Case 1) Full-thickness resection of lid with a 3.0 x 3.5 mm tumor at the lid-margin (between arrows). The orbicularis muscle (asterisk) and tarsus (arrowhead) are present (hematoxylin and eosin x 15).

Case two. A 61-year-old white female presented with a cystic appearing lesion of the left upper eyelid margin with a duration of three months. The clinical diagnosis was chalazion. The patient underwent excision of the lesion and a diagnosis of Merkel cell tumor was made. One month later, the patient presented with recurrence. A second excision was performed, and she has been free of tumor for eight months.

Pathologic findings

Light microscopy. The tumor in both cases was nonencapsulated and composed of large, round-to-oval cells with scant cytoplasm, round-shaped nuclei, and variably distinct cell borders (**Figure 2**). The cells were arranged in lobules and cords with associated mild acute and chronic inflammatory

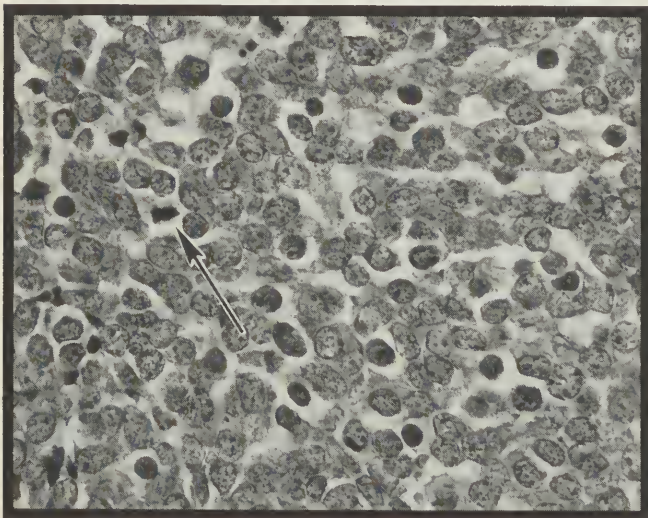


Figure 2. Tumor is composed of large, round-to-oval cells with uniform nuclei that have a fine chromatin pattern and occasional micronucleoli and a thin rim of cytoplasm. Mitotic activity (arrow) is present (hematoxylin and eosin x 575).

cell infiltration. The tumor infiltrated the orbicularis muscle and the muscle of Riolan. Marked mitotic activity was present in both cases with 180 and 132 mitoses per 40 high power fields in case one and two, respectively. The tumor cells stained positively for cytoplasmic granules with the Grimelius stain.

All surgical margins of the specimen were tumor-free in case one, and one margin was positive for tumor in case two.

Electron microscopy. Transmission electron microscopy was performed in case one. The predominant cells were arranged in clusters and had a trabecular pattern in some areas. The cells contained scant cytoplasm and nuclei with one or two nucleoli and finely dispersed chromatin. Rare membrane-bound cytoplasmic electron-dense core granules, occasional juxtanuclear intermediate filaments measuring 10 nm in diameter, and occasional junctional complexes were present (**Figure 3**). Occasional small cells with a round-to-oval nucleus, abundant heterochromatin, scant cytoplasm with free ribosomes, and no junctional complexes (lymphocytes) were observed among the tumor cells. Similar cells with abundant cytoplasm containing numerous rough endoplasmic reticulum (plasma cells), as well as medium-sized cells with abundant membrane-bound multimembranous material (mast cells), were also present.

Immunohistochemical analysis. Paraffin sections of the

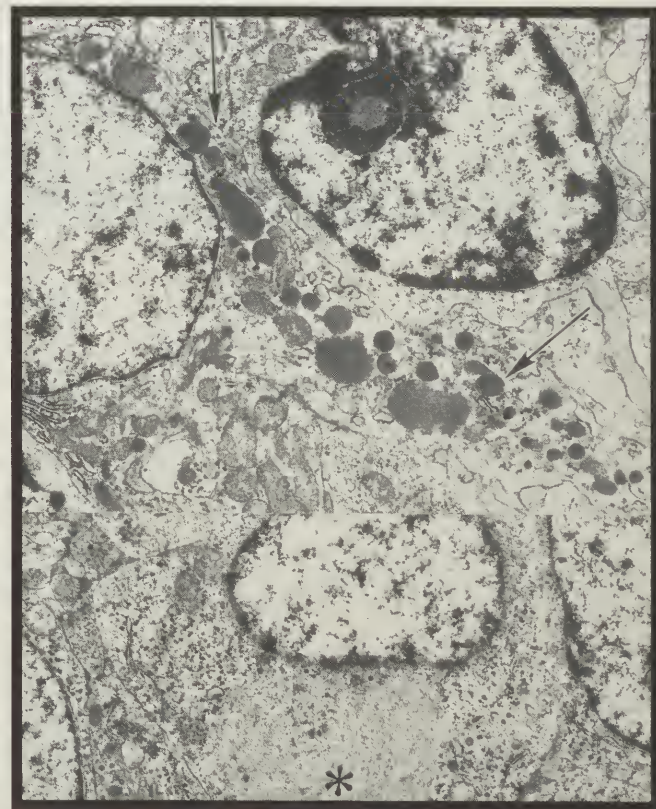


Figure 3. Ultrastructural appearance of tumor cells with membrane-bound electron dense core granules (arrows, top) and paranuclear intermediate filaments (asterisk, bottom) (top and bottom x 10,000).

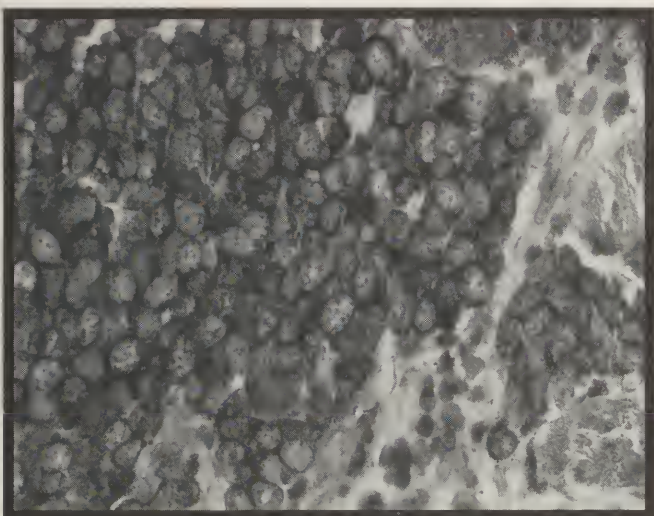


Figure 4. Tumor cells stain intensely for neuron-specific enolase (immunoperoxidase x 575).

tissue in both cases were stained with hematoxylin-eosin, periodic acid-schiff (PAS), and neuron-specific enolase (**Figure 4**). In addition, case one was stained for cytokeratin, neurofilaments, leukocyte common antigen, and S-100.

Neuron-specific enolase was positive in both cases. Some tumor cells had mild, positive, staining reaction for cytokeratin. Marker studies for neurofilaments, S-100, and a common leukocyte antigen were negative.

Comment

In 1875, Merkel first described clear oval cells occurring in continuity with dermal nerve endings located in the basal epidermis.⁶ He called these cells *Tastzellen*.⁶ Merkel noted that these peculiar cells were penetrated by nerve fibers whose myelin sheath terminated outside the cell. He postulated that their function was similar to Meissner bodies. In 1972, Toker³ recognized a distinctive primary neuroendocrine carcinoma of the skin which he postulated originated from sudoriferous glands. He called the tumor trabecular carcinoma of the skin, based on its histologic trabecular pattern. Winkelmann and Breathnach,¹⁹ in 1973, reviewed Merkel cell characteristics and predicted that the Merkel cell could give rise to tumors. Ultrastructural studies by Tang and Toker⁴ in 1978 revealed that trabecular carcinoma of the skin was not of sweat gland origin but contained dense core neurosecretory granules suggesting cutaneous Merkel cell origin. Sibley⁵ and Sidhu⁷ subsequently characterized the histologic and ultrastructural features of this distinctive skin tumor. Champion,⁸ in 1982, was the first to report a Merkel cell neoplasm of the eyelid in the ophthalmic literature.

By light microscopy, the Merkel cell is a clear, non-dendritic, argyrophilic, and variable PAS positive cell located in the basal layer of the epidermis.¹ Electron microscopy discloses numerous membrane-bound dense core granules 80–120 nm in diameter located in the cytoplasm.² The cell is in close association with an expanded axon terminal above the

basal epithelium. Desmosomal junctions secure the Merkel cell to adjacent keratinocytes. Despite having dense core granules, the Merkel cell does not appear to be of the APUD (amine precursor uptake and decarboxylation) system.¹

The typical histologic appearance of a Merkel cell tumor is characterized by sheets of cells in a diffuse pattern that infiltrate the dermis or, less often, the subcutaneous tissue. Other growth patterns—trabecular³ and pseudoglandular²⁰—may be present. The cells are usually uniform in size, non-cohesive, and round-to-oval in shape. Cytoplasm is scant. The nuclei are also round-to-oval with fine and granular cytoplasm with two to three small nucleoli adjacent to the nuclear membrane. The mitotic index is typically high. Due to the immature blastic features of the tumor, the histologic diagnosis can be extremely difficult and the tumor may be misdiagnosed as a malignant lymphoma. Molding may be a distinguishing, light microscopic feature.²⁰ Leong²¹ noted a ball-in-mitt configuration in which crescentic cells wrapped around oval cells in 12 of 13 cases of Merkel cell carcinoma of the skin.

Special stains aid in the diagnosis and demonstrate the endocrine nature of Merkel cell tumors. The Grimelius silver stain for neurosecretory granules can be focally positive.²¹ Formalin-preserved specimens have a lower sensitivity for positive Grimelius-staining than those preserved in Bouin's fixative.^{20–22} Stains for melanin (Masson-Fontana) and amyloid (congo red) are typically negative, although rare positive cases have been reported.^{23,24}

Immunohistochemical staining may also be enlisted to distinguish Merkel cell tumors from other cutaneous neoplasms. Neuron-specific enolase appears to be the most useful diagnostic marker. According to the series by Leong,²¹ neuron-specific enolase was the most consistent marker, being present in 12 of 12 tumors. More recently, staining for cytokeratin has been found to be strongly reactive in Merkel cell tumors^{21,25} in a round, globular, juxtanuclear pattern. Neurofilaments have also been identified in Merkel cell tumors.^{21,25} Peptide hormones may be expressed by Merkel cell tumors and include adrenocorticotrophic (ACTH), calcitonin, somatostatin, and insulin staining reported.²³ Leukocyte common antigen and melanoma-associated antigen (HMB-45) are negative. Pajor and coworkers¹⁰ found focal peanut agglutinin positivity in six of 10 Merkel cell tumors and suggest that this is an additional tool for use in the diagnosis of Merkel cell tumors.

Electron microscopy confirmation is desirable when the light microscopy findings are atypical. Ultrastructural studies are essential when the diagnosis is uncertain by light microscopy due to the immature blastic feature of this tumor. Ultrastructural analysis discloses large round-to-oval nuclei with small eccentric nucleoli.^{7,26} The cytoplasm is poorly differentiated with small numbers of mitochondria, rough endoplasmic reticulum, and prominent Golgi apparatus.^{4,7,23,27} The most prominent features are 120–210 nm diameter dense-core neurosecretory granules located in the peripheral

cytoplasm^{7,20-23,27} and perinuclear aggregates of intermediate (10 nm) microfilaments.^{5,7,21} Zonula adherens and undifferentiated intercellular junctions have been observed.^{9,27} There has been some debate regarding the true origin of the Merkel cell. It has been suggested that the Merkel cell is of neural crest origin, as its cytoplasmic dense-core granules are similar to those of the APUD cell system.^{1,26,28,29} However, the dense-core granules have not been found to contain catecholamines or neurotransmitters in humans. The polypeptide neurotransmitter Met-enkephalin has been demonstrated in primate Merkel cells supporting a link to the APUD system.³⁰

The differential diagnosis includes the primary cutaneous neoplasms of the eyelid, metastatic oat cell carcinoma, islet cell carcinoma, neuroblastoma, plasmacytoma, and large cell lymphoma. By light microscopy, metastatic oat cell carcinoma, metastatic primitive neuroendocrine tumors, and large cell lymphoma pose the greatest difficulty in diagnosis. Morphologic features of value in differentiating similar tumors include keratinization in squamous cell carcinoma, melanosomes in malignant melanoma, and intracytoplasmic lipid in sebaceous cell carcinoma. Immunohistochemical staining can exclude tumors morphologically similar to Merkel cell tumors. Neuroblastoma stains for neuron-specific enolase but is cytokeratin negative.⁹ Large cell lymphoma stains for leukocyte common antigen and will not stain for neuron-specific enolase, cytokeratin, or neurofilaments.⁹ Metastatic neuroendocrine tumors may be differentiated by their lack of a juxtanuclear staining pattern for cytokeratin and neurofilament.²¹ The presence of perinuclear intermediate filaments^{25,31} is perhaps the key identifying characteristic of the Merkel cell tumor that differentiates it from the metastatic neuroendocrine carcinoma.

The clinical diagnosis of Merkel cell tumor should be considered whenever an elderly patient presents with a growing violaceous skin nodule or recurrent chalazion of the upper eyelid.

The clinical features of the 11 cases previously reported in the ophthalmic literature and our two cases are summarized. The mean age at presentation was 76 years and all patients were of white race. The race of four patients was not reported. There was a predisposition for women. All tumors occurred in the upper eyelid, supporting the hypothesis that sun and ultraviolet light-induced damage predispose one to the development of this tumor.

Merkel cell tumor of the lower lid has been reported in the dermatology literature.⁷ In a review of the literature, Hitchcock and coworkers³² reported that 50 percent of lesions occurred in sun-exposed areas of the head and neck, males and females were equally affected, and the mean age at presentation was 67.9 years.

Lymph node metastases^{8,10} and local recurrences^{9,17} have occurred with Merkel cell tumors of the eyelid. Metastases and local recurrence are common in this skin tumor.³² Death was attributed to metastatic disease in 20 percent of patients.

Of the 43 cases of Merkel cell carcinoma of the skin reported by Sibley and coworkers,⁵ 30 percent of patients had local recurrence, 65 percent had lymph node metastases, and a third died with metastatic tumor.

Successful treatment is determined by early diagnosis and prompt complete excision. The tumor should be excised with frozen section monitoring of surgical margins to assure completeness of excision. The clinical presentation often belies the aggressive nature of this tumor and the diagnosis may often be made or suspected only after histopathologic evaluation. Examination of regional lymph nodes and biopsy of suspicious nodes are the next steps in management of Merkel cell tumors. Information on the use of radiation and systemic chemotherapy for the treatment of Merkel cell tumors of the eyelid is limited due to the small sample size; however, these treatment modalities should be considered for extensive primary lesions, metastases, or recurrence.^{20,33} Careful follow-up evaluations are necessary.

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Council Highlights

The following information is presented in response to the recommendation approved by Council at its meeting on November 21, 1991: "Med Chi should distribute the AMA information concerning biomedical research to all Med Chi physicians."

What biomedical research has accomplished

In an appearance on the "Today Show" in 1985, the co-director of People for the Ethical Treatment of Animals commented on the achievements of biomedical research using animals: "If it were such a valuable way to gain knowledge, we should have eternal life by now."

Obviously, she missed the point. The issue is not what *has not* been accomplished through the use of animals in biomedical research, but what *has* been accomplished.

Scientists agree that virtually every advance in medical science in the 20th century—from antibiotics and vaccines to antidepressant drugs and organ transplants—was achieved either directly or indirectly through the use of animals in laboratory experiments.

The list of accomplishments is long, indeed:

Pre-1900	Treatment of rabies, anthrax, beriberi (thiamine deficiency), and smallpox. Principles of infection control and pain relief. Management of heart failure.
Early 1900s	Treatment of histamine shock, pellagra (niacin deficiency), and rickets (Vitamin D deficiency). Electrocardiography and cardiac catheterization.
1920s	Discovery of thyroxine. Intravenous feeding. Discovery of insulin for diabetes control.
1930s	Therapeutic use of sulfa drugs. Prevention of tetanus. Development of anticoagulants, modern anesthesia, and neuromuscular blocking agents.
1940s	Treatment of rheumatoid arthritis and whooping cough. Therapeutic use of antibiotics, such as penicillin, aureomycin, and streptomycin. Discovery of the Rh Factor. Treatment of leprosy. Prevention of diphtheria.
1950s	Prevention of poliomyelitis. Development of cancer chemotherapy. Open-heart surgery and cardiac pacemaker.
1960s	Prevention of rubella. Corneal transplant and coronary bypass surgery. Therapeutic use of cortisone. Development of radioimmunoassay to measure minute quantities of antibodies, hormones, and other substances in the body.
1970s	Prevention of measles. Modern treatment of coronary insufficiency. Heart transplant. Development of non-addictive pain killers.

1980s	Use of cyclosporine and other anti-rejection drugs. Artificial heart transplantation. Identification of psychophysiological factors in depression, anxiety, and phobias. Development of monoclonal antibodies for treating disease.
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This list could be much longer, but the point is obvious: Without research involving laboratory animals, these advances in medical science would have been impossible.

Humans aren't the only beneficiaries of animal research. The welfare of animals themselves has been greatly improved. Here are just a few of the advances in veterinary medicine:

Vaccination against distemper, rabies, parvo virus, infectious hepatitis, anthrax, and tetanus.
Treatment for animal parasites such as hookworm and heartworm.
Orthopaedic surgery for horses.
Surgery to correct hip dysplasia in dogs.
Experimental radiation techniques and immunotherapy for cancer in dogs.
Identification and prevention of brucellosis and tuberculosis in cattle.
Treatment of feline leukemia.
Vaccine for Newcastle disease in poultry.
Embryo transfer techniques to improve breeding.
Improved nutrition for pets.

November 1990



Key facts on animal rights controversy

Animal Welfare Act

- Passed in 1966 and amended in 1970, 1976, and 1985.
- Protects against theft of animals for sale to research labs.
- Stipulates humane treatment for animals in universities, medical schools, hospital labs, and other research institutions.
- Establishes physical environment necessary to assure the well-being of all animals used in research laboratories.
- Provides for adequate housing for all laboratory animals.
- Provides guidelines for veterinary treatment, anesthesia, and formation of Animal Care and Use Committee at all research institutions receiving federal funding. Committee must include lay member from local community.
- Monitored by U.S. Department of Agriculture.

Health Research Extension Act

- Passed in 1985 (amendment to Public Health Service Act of 1978).
- Stipulates that NIH promote 'alternatives' to animal use in biomedical research.
- Dictates that Animal Care and Use Committee consist of at least one veterinarian, one non-scientist and, one person not affiliated with institution.

Council Highlights

Disease statistics

Two-thirds of Nobel Prizes awarded since 1901 made for discoveries that required the use of animals. For example, relationship between cholesterol and heart disease studied in dogs, 1985; link between virus and cancer studied in chickens, 1966; transplantation studied using cattle, mice, and chicken embryos, 1960; and kidney and bone marrow transplantation, 1990.

Two decades ago, kidney disease killed 20,000 per year in the United States. Today that number has decreased by 40 percent (still kills 12,000 each year). Seventy thousand patients in United States are on renal dialysis (developed using dogs). Seven thousand patients receive kidney transplants each year in United States (developed using dogs).

Polio afflicted 58,000 in 1952 in United States and only four in 1984 (vaccine developed using monkeys).

Heart disease still kills 500,000 each year in United States. Sixty million United States residents have some form of heart or vascular disease. Two hundred million coronary artery bypass graft surgeries performed each year in United States (developed using dogs).

Animal rights groups

More than 400 groups exist with total budget of over \$200 million per year in United States alone. Since 1982, more than 100 new radical groups formed.

More than 35 labs have been vandalized and more than 2,000 animals have been stolen in United States alone between 1988 and 1990.

Tactics include: break-in, civil disobedience, vandalism, picketing, threats (personal and property), sit-ins, letter-writing campaigns (media and elected officials), harassment of scientists, boycotts of products, and lawsuits.

Responsible for millions of dollars in damage. Includes destruction of lab under construction at University of California—Davis causing over \$3.5 million damage.

Since 1984, number of Americans belonging to animal rights groups has increased five times to approximately 10 million. Recent ALF break-in at University of Oregon. Perpetrators reported to the press that no violations of USDA requirements were noted.

Pound animals

More than 10 million animals killed annually in pounds and shelters.

Total annual cost of pet animal control in United States is \$500 million.

Forty to eighty percent of animals in pounds and shelters were brought in by owners.

Dogs and cats from pounds represent less than one-tenth of 1 percent of animals used for research per year in United States.

Statistics reveal that only one animal is used for research purposes every ten years for each United States citizen. Nine out of 10 times, that animal is a mouse or rat.

In 1982–83, 17–22 million animals were used for research. Seventy-five to ninety percent were rodents. A total of 138,000 were dogs; 55,000 were cats.

Forty percent reduction in total number of animals used in the 10-year period 1968–1978.

Cost of pound animal is less than \$100. Purpose-bred animal is over \$500.

Research funding

Only about 25 percent of approved grants are funded by United States government.

Duplication of research is highly unlikely.

Painful experiments

1984 USDA report indicates

61 percent of animals used in experiments did not involve pain;

31 percent of animals subjected to pain BUT were anesthetized prior to experiment; and

8 percent of animals used in experiments that involved pain but purpose of experiment was to study pain.

Chronic pain is one of the most costly health problems in United States.

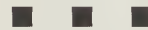
Fifty billion dollars spent in United States each year on direct medical expenses, lost productivity, and lost income associated with pain.

Three hundred thousand traumatic injuries each year in United States that involve chronic pain.

Public surveys

All public surveys have shown overwhelming support for continued animal use in biomedical research.

Fear of biomedical research institutions using lost or stolen pets unfounded. Foundation for Biomedical Research survey of police and animal control agencies in 10 largest United States cities reveal no reported thefts of animals with subsequent sale to research institutions. Stolen dogs are most often pedigree animals to be resold as pets.



Facts about biomedical research

Two-thirds of the Nobel prizes awarded since 1901 were for discoveries requiring the use of animals. These included research that established the relationship between cholesterol and heart disease.

Two decades ago, kidney disease killed 20,000 people every year in the United States. Today that number has decreased by 40 percent thanks to animal research.

In 1952, polio afflicted 58,000 people. A vaccine developed using monkeys has virtually wiped out that dread disease.

Many more vaccines were developed using animals. Measles, rubella, tetanus, mumps, diphtheria, and many other diseases can be prevented as a result.

Special techniques like those used in open-heart surgery, microsurgery, and organ transplants were developed through animal research.

If you've been hospitalized, you may have benefitted from anesthesia, intravenous feeding, or the use of non-addictive pain killers. Animal research contributed to these techniques.

Following are just a few of the other diseases and conditions studied through animal research: diabetes, cholera, hemophilia, depression, muscular dystrophy, rickets, glaucoma, Parkinson's, rabies, spinal cord injury, and hepatitis.

Council Highlights

To receive further information on biomedical research, write: Biomedical Research, American Medical Association, 515 North State Street, Chicago, IL 60610.

We all benefit...

Let's ensure the future of biomedical research

We all live in a much healthier world than our parents did. Physicians are curing and preventing diseases that, until recently, were thought untreatable. Millions are enjoying longer, healthier lives.

The major reason for these successes is biomedical research. Research has improved our understanding of how biological systems function and advance our medical knowledge. The continued progress of research is essential to answering many medical questions that plague humankind.

Research requires animal testing

Today, breakthroughs in medicine are threatened by a small group of individuals who object to further medical progress, especially research that uses animals. With protests, with political pressure, with bomb threats, and with other tactics, they fight to stop research using animals at all costs.

Their efforts ignore one fact. Virtually every advance in medical science during the 20th century has directly or indirectly involved the use of animals in laboratory studies.

Scientists need to test theories, develop treatments or procedures, and prove the safety of new medicines. Some experiments can be done using cell cultures, computers, or other methods. But, at one point or another, biomedical research requires testing in mammals.

The only alternative is discontinuing the vital research that could one day produce cures for Alzheimer's, AIDS, heart disease, and cancer. This alternative is clearly not acceptable nor ethical.

Activists call research unethical

Animal activists do not see the need for animal testing. They perceive research as exploitation, despite its value in curing disease and easing human suffering.

Current activist groups include:

Physicians Committee for Responsible Medicine (PCRM) professes to speak for organized medicine. Only 2,000 of the group's 30,000 members are allegedly physicians.

People for the Ethical Treatment of Animals (PETA) acts on the

premise that all mammals are created equal. PETA is the most active and visible militant organization nationally.

Animal Liberation Front (ALF) has been identified by Scotland Yard as a terrorist organization. ALF members have raided laboratories, destroying equipment, records, and buildings.

Members of these organizations have actively terrorized universities, medical institutions, physicians, and researchers involved in vital medical studies. Their tactics have driven scientists from the medical field and needlessly increased the cost of research by billions of dollars.

These groups want a total ban on research using animals. This ban would clearly slow the pace of health-related breakthroughs, impeding new procedures and technologies that benefit patients. The potential damage to human health cannot be measured.

Public, physicians support research

Most people believe that the cost of a research ban is too high. A 1989 Gallup survey reported that 77 percent of Americans believe the use of animals in research is necessary for progress in medicine. A 1988 survey showed that 97 percent of U.S. physicians support using animals in clinical research.

At the same time, the public believes that animals should be treated humanely. Researchers are required to obey laws that establish standards for animal research. Efforts are made to reduce the number of animals used or find alternative methods whenever practical or possible.

Animals activists have sought to limit animal research by lobbying for more restrictive laws. In some states, for example, they have succeeded in banning the use of pound animals for research. Higher costs are the result, adding a new roadblock to scientific progress.

What lies ahead?

Biomedical research is attempting to solve our age's most perplexing medical problems. The continued pursuit of answers, within firmly regulated guidelines, must continue. You can help guarantee this happens:

Before you make contributions to any animal welfare group, check its background and goals.

Oppose local, state, or federal legislation that may hamper biomedical research. Existing laws are adequate to ensure humane treatment of animals.

Support medical research through your contributions to reputable voluntary health organizations. ■

Imaging Case of the Month

A 13-year-old white male presented with the insidious onset of painful swelling in his left index finger. There was no history of trauma, penetrating wound, or insect bite. Up to three to four adult aspirin were taken to relieve the pain. On physical examination, diffuse swelling involved the proximal interphalangeal (PIP) joint and extended proximally toward the metacarpophalangeal (MCP) joint. There was full range of motion and no pain to direct palpation. White blood count (WBC), sedimentation rate, and alkaline phosphatase values were normal.



Figure 1.



Figure 2.



Figure 3.



Figure 4.



Figure 5.

Imaging Case of the Month

Osteoid osteoma in a phalanx

Figure 1. Plain radiograph shows an area of lucency with a possible sclerotic center (arrow).

Figure 2. Radionuclide bone scan of a blood pool image shows a tiny focus of more intense rounded activity distally (arrow) corresponding to area of lucency on the radiograph.

Figure 3. Radionuclide bone scan (delayed image) also demonstrates an intense rounded area of increased tracer activity, (arrow), corresponding to radiographic lucency.

Figure 4. CT scan: Transaxial section delineates the extent of reactive sclerosis, the lucent lesion, and the calcified central nidus (arrow).

Figure 5. CT scan: Direct sagittal section delineates the extent of reactive sclerosis, the lucent lesion, and the calcified central nidus (arrow).

Imaging findings

Plain radiograph (**Figure 1**) demonstrated soft tissue swelling surrounding a slightly enlarged, elongated left second proximal phalanx, with chronic type cortical thickening, and distally, a tiny round area of lucency with a possible sclerotic center. A three-phase radionuclide bone scan (TPBS) was performed to determine the physiologic and metabolic status of this lesion. The radionuclide angiogram portion (not shown) demonstrated minimal late capillary phase increased activity about the entire proximal phalanx. The blood pool or tissue phase images (part 2 of the TPBS, **Figure 2**) showed mildly increased activity (representing increased vascularity) about the proximal phalanx with a tiny focus of more intense rounded activity distally, corresponding to the area of lucency on the radiograph. This small area does not reproduce well. The delayed image (part 3 of the TPBS, **Figure 3**), in addition to showing mild diffusely increased tracer uptake involving all of the proximal phalanx, demonstrated an intense round area of increased tracer activity also corresponding to the radiographic lucency. These findings were most consistent with an active osteoid osteoma. The lack of intense increased perfusion on the radionuclide angiogram and the focal round activity on the other phases made infection less likely, but not totally excludable. Thin section computed tomography (CT) scanning was done to determine detailed anatomy prior to surgery. Transaxial (**Figure 4**) and direct sagittal (**Figure 5**) sections delineated the extent of reactive sclerosis, the lucent lesion, and the calcified central nidus.

Pathological diagnosis

Focus of reactive bone with prominent osteoblasts, consistent with osteoid osteoma

Discussion

Osteoid osteoma is a benign tumor of bone seen mainly in children and young adults. The actual lesion is a nidus, which appears radiolucent on the radiograph. It is composed of highly vascularized osteogenic connective tissue (focal tracer uptake on blood pool and delayed images). When the nidus is in the cortex, as in this patient, there is significant reactive sclerosis with cortical thickening and a solid periosteal response surrounding the nidus. Initially uncalcified, the nidus often develops calcification within its center.^{1,2}

Pain, often described as deep and aching and worse at night, is the most characteristic symptom of osteoid osteoma. It is not usually relieved by exercise or rest, but about 65 percent of patients report dramatic relief with aspirin. Radionuclide bone scanning has been most useful since pain is usually present for many months prior to radiographic evidence of the lesion.^{3,4}

Osteoid osteoma does not commonly occur in the hand or wrist, with various studies suggesting less than 10 percent of lesions in these areas. Fifty percent of lesions occur in the femur and tibia, while spine lesions involving the lamina, pedicles, and facets are often the cause of unexplained back pain. This patient illustrates the soft tissue swelling that occurs in the fingers and the overgrowth of bone described in children. Differential diagnosis includes Garre's chronic sclerosing osteomyelitis; Brodie's abscess; and, especially in the phalanges, epidermoid cysts, enchondromas, and glomus tumors. Surgery is indicated to relieve intractable pain and restore function. Effective surgery requires complete removal of the nidus.

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EDGAR C. FEARNOW, M.D.
Department Editor

Metastatic neoplasms from an unknown primary

Approximately 5–10 percent of cancer patients present with signs of metastatic disease, but routine workup usually reveals the site of the primary neoplasm. However, some patients have an occult primary lesion that may go undetected clinically during the entire course of the disease. Even at autopsy, the primary site may not be identified in up to 30 percent of cases.^{1,2} An analysis of over 1,500 patients from the Yale Tumor Registry showed that the proportion of cases with unknown primary cancer was approximately 3 percent per year and that this proportion was fairly constant throughout the decades from the 1940s to 1980, despite advances in diagnostic techniques.³ Although newer procedures, such as magnetic resonance imaging (MRI) scans and monoclonal antibodies, may improve the diagnostic assessment in some of these patients, cancer patients who present with metastatic disease from an uncertain primary remain a unique subset. The evaluation and treatment of these patients must be individualized, based on pathology, location of disease, and clinical status.⁴

Carcinoma of unknown primary (CUP) can generally be divided into three major groups: squamous cell carcinoma, adenocarcinoma, and undifferentiated malignancies. The cell type and the pattern of metastasis can help the clinician narrow down the possible primary sites. For example: a solitary axillary node with adenocarcinoma in a woman is likely to be breast cancer; a cervical node with squamous cell is likely to represent a primary in the head and neck region; and bone metastasis in an elderly man could be due to prostate cancer. Undifferentiated malignancies are especially challenging since the primary site is particularly difficult to assess on the basis of clinical and radiographic findings. However, since these tumors can have a gratifying response to chemotherapy resulting in long-term survival⁵ and even cure, an extensive search for a primary lesion may yield no additional benefit.

The evaluation of patients with metastatic disease should begin with a complete history and physical examination. The examination must include careful attention to the axillary and inguinal nodes, the breasts (both men's and women's), anorectal and genital areas, and the exposed and unexposed skin. Routine laboratory studies (complete blood count, full chemistry profile, and urinalysis) may help to identify other metastatic sites. Chest x-ray is also essential. Bone scan is virtually never helpful in establishing the location of the primary, but may be important in evaluating involvement of weight-bearing bones prone to pathologic fractures. Mammography is relatively inexpensive and should be performed in all women with adenocarcinoma since the implication for specific therapeutic intervention is quite significant. Computed tomography (CT) scans of the abdomen may identify pancreatic or renal tumors, but these malignancies are essen-

tially untreatable. The benefit of gastrointestinal (GI) studies and endoscopy is questionable for patients who have no GI symptoms and who are hematest negative.⁶ MRI probably adds little to the diagnosis and therapy, but few studies have addressed the value of this new modality. Costly evaluations should be initiated only if the results will have an impact on therapeutic decisions.⁴

Biopsy of clinical or radiographic abnormalities is obligatory. Occasionally, the tissue specimen in a patient with widely metastatic disease will yield a specific diagnosis, such as multiple myeloma or malignant melanoma, that may guide treatment decisions. Fine-needle aspiration or CT-directed biopsy is often sufficient to make an initial assessment. However, additional tissue may be required for special pathology studies in difficult cases. Monoclonal antibodies can now be used as immunoperoxidase stains to differentiate lymphoma from carcinoma and to further identify melanoma, germ cell tumors, and several other specific malignancies.⁷ When open biopsy is recommended, the treating physician should carefully consider the diagnostic possibilities in order to facilitate other special studies, such as estrogen receptors and electron microscopy, that may have additional benefit in resolving diagnostic dilemmas.

Patients who present with metastatic carcinoma in the cervical lymph nodes require special diagnostic considerations. When biopsy reveals squamous cell carcinoma, these patients should have complete head and neck examination (from the nasopharynx to the subglottic area) and complete chest evaluation. Open biopsy should be avoided initially, but needle aspiration cytology can be performed at any time. Surgical excision followed by radiation therapy to the neck can result in three-year survival of 30–50 percent, even when the primary lesion is occult. If the metastases in the neck are adenocarcinoma, major attention should be directed to the GI tract and lungs. A clinical history of prior irradiation to the head or neck could suggest an increased risk of thyroid or salivary gland tumors. Thyroid carcinomas may present with palpable cervical nodes, and nucleotide scan can be helpful in that instance. CT scanning of the neck can help to establish the extent of gross disease for treatment planning, but is not more reliable than physical examination in diagnosing minimal disease (i.e., lymph nodes 0.5 cm or less in diameter).

The overall prognosis in patients with CUP is quite poor—with median survival of less than six months—but approximately 10 percent of patients survive five years. The majority of cases are adenocarcinoma, but the pathology is undifferentiated in approximately 30 percent. Despite improvement in the sensitivity of new radiologic procedures, the primary lesion in most patients with CUP remains obscure throughout the clinical illness. Autopsy series reveal that lung cancer is the most likely origin for tumors above the

diaphragm, and pancreatic cancer is most likely for those below the diaphragm, although occult primaries have been identified postmortem in virtually every organ.⁸

CUP is an uncommon clinical syndrome, but several series have been published that provide guidelines for clinical management.⁹⁻¹¹ Patients who have a solitary area of metastatic disease should be treated with local therapy, including surgical excision and locoregional radiation. Female patients occasionally present with peritoneal carcinomatosis with no obvious primary in the ovaries; nevertheless, the pattern of metastatic disease at laparotomy is typical of ovarian cancer, and chemotherapy directed at this disease can induce long-term remissions.¹² Other patients with adenocarcinoma and good performance status can be treated with adriamycin-based regimens that may result in responses in 35 percent of patients. Patients with poorly differentiated carcinomas are an interesting subgroup. Durable complete remissions may be seen in these patients following treatment with platinum combination therapy or with multi-agent regimens commonly used for lymphomas. A directed approach to treatment based on location of disease, histopathology, and pattern of metastasis can result in effective palliation.

In summary, patients with carcinoma of unknown primary represent a heterogeneous group. Evaluation should be individualized based on potential treatment strategies. The search for a primary lesion begins with careful review of the pathology, although the identification of the primary usually eludes the clinician if the initial examination and workup is negative. Patients with localized disease should be treated with local therapies (surgery and/or radiation). Metastatic disease can be treated with empiric chemotherapy regimens using adriamycin or platinum, based on assessment of certain clinical features. Although the average survival is quite short, some patients respond well to therapy and survive five years or more, justifying aggressive therapy in patients with good performance status.

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Tumor conferences are held weekly on Tuesday between 8 and 9 a.m. in Room NBW74 at the University of Maryland Medical System. Physicians are welcome to attend this open meeting and to present cases and pathology slides. Call 301-328-5224 by noon Monday to be placed on the schedule. Surgical Oncology Program, University of Maryland Medical System, Room N13E02, Baltimore, MD 21201. ■

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Board of Physician Quality Assurance Actions

In the matter of
Yin Chuan Hung, M.D.
before the
Maryland Board of
Physician Quality Assurance

Order terminating probation and reinstating license

By Order dated January 19, 1988 (the 1988 Order), the Commission on Medical Discipline (the Commission), predecessor agency to the Board of Physician Quality Assurance (the Board), found Yin Chuan Hung (the Respondent) guilty of committing prohibited acts as set forth in Health Occupations Article, *Annotated Code of Maryland* (HO) §14-504. Specifically, the Commission found Respondent guilty of §14-504(4). The Commission suspended the Respondent's license and stayed the suspension, conditioned upon the Respondent complying with conditions of probation (the Conditions of Probation). The Order further provided that on or after February 1, 1991, if the Respondent demonstrated to the Board's satisfaction that Respondent had complied with the terms and condition of his probation, the Board would entertain a petition for altering the terms of Respondent's probationary status.

By letter dated September 12, 1991, Respondent petitioned the Board for Termination of Probationary Status and Reinstatement of His License (Petition) to practice medicine in Maryland. At its meeting on October 9, 1991, the Board, through its Case Resolution Conference (the Conference), reviewed Respondent's Petition.¹ Based upon the Board's review of the Petition, the Board determined that Respondent has fulfilled the Conditions of Probation contained in the 1988 Order.

Findings of fact and conclusions of law

The Board concludes, as a matter of law, that Respondent has satisfactorily complied with all conditions of probation as set forth in the 1988 Order.

Order

Upon the foregoing Findings of Fact and Conclusions of Law, it is this 15th day of October 1991

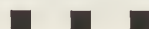
ORDERED that effective as of the date of this Order, the Conditions of Probation imposed upon Respondent's practice of medicine by the Board's 1988 Order are hereby TERMINATED and of no further force and effect; and be it further

ORDERED that Respondent's license to practice medicine in the state of Maryland be REINSTATED without any condition or restriction whatsoever; and be it further

1. At its meeting on June 26, 1991, the Board delegated to the Conference the responsibility of reviewing and evaluating petitions for reinstatement of licenses without probationary conditions. If the Conference determines that all probationary conditions have been met, the petitioner's license will be reinstated without conditions upon the Board Chairperson's execution of an Order terminating the conditions.

ORDERED that this is a Final Order and as such is considered a public document pursuant to the Maryland Public Information Article, State Government Article, *Annotated Code of Maryland*, §§10-611 *et seq.*, specifically §10-617(h)(2)(vi).

ISRAEL H. WEINER MD, Chairperson
Maryland Board of Physician Quality Assurance



In the matter of
Abdoul Edward Komeh, M.D.
before the
Maryland Board of
Physician Quality Assurance

Final order

On June 20, 1990, Abdoul Edward Komeh, M.D. (the Applicant) applied to the Board of Physician Quality Assurance (the Board) for reinstatement of medical licensure. The Board, pursuant to the Maryland Medical Practice Act (the Act), *Md. Health Occ. Code Ann.* (HO) §14-205, notified the Applicant that there was reason to issue an initial denial of the Applicant's application for reinstatement of licensure.

Pursuant to HO §14-205(a)(1)(iii), the Board found that there were grounds for action under HO §14-404. Specifically, the Board charged that the Applicant:

Fraudulently or deceptively obtains or attempts to obtain a license for the applicant ...; [HO §14-404 (a)(1)].¹

Willfully makes or files a false report or record in the practice of medicine; [HO §14-404(a)(11)].²

Is disciplined by a licensing or disciplinary authority or convicted or disciplined by a court of any state ... for an act that would be grounds for disciplinary action under this section. [HO §14-404(a)(21)].³

Is convicted of or pleads guilty ... with respect to a crime involving moral turpitude ...; [HO §14-404(b)].⁴

The grounds for disciplinary action under HO §14-404(a)(21) are as follows:

1. Section 1, Chapter 109, Acts 1988, effective July 1, 1988, recodified former HO §14-504(1) as HO §14-504(a)(1). Section 11, Chapter 6, Acts 1990, approved February 16, 1990, effective on or about January 1, 1991, renumbered HO §14-504(a)(1) as HO §14-404(a)(1).
2. Section 1, Chapter 109, Acts 1988, effective July 1, 1988, recodified former HO §14-504(12) as HO §14-504(a)(11). Section 11, Chapter 6, Acts 1990, approved February 16, 1990, effective on or about January 1, 1991, renumbered HO §14-504(a)(11) as HO §14-404(a)(11).
3. Section 1, Chapter 109, Acts 1988, effective July 1, 1988, recodified former HO §14-504(22) as HO §14-504(a)(21). Section 11, Chapter 6, Acts 1990, approved February 16, 1990, effective on or about January 1, 1991, renumbered HO §14-504(a)(21) as HO §14-404(a)(21).
4. Section 1, Chapter 109, Acts 1988, effective July 1, 1988, deleted HO §14-504(6) and enacted HO §14-504(b). Section 11, Chapter 6, Acts 1990, approved February 16, 1990, effective on or about January 1, 1991, renumbered HO §14-504(b) as HO §14-404(b).

Board of Physician Quality Assurance Actions

Fraudulently or deceptively obtains or attempts to obtain a license for the applicant ...; [HO §14-404(a)(1)].

Is guilty of immoral or unprofessional conduct in the practice of medicine; [HO §14-404(a)(3)].⁵

Willfully makes or files a false report or record in the practice of medicine; [HO §14-404(a)(11)].

Is disciplined by a licensing or disciplinary authority or convicted or disciplined by a court of any state ... for an act that would be grounds for disciplinary action under this section; [HO §14-404(a)(21)].

Is convicted of or pleads guilty ... with respect to a crime involving moral turpitude ...; [HO §14-404(b)].

Pursuant to HO §14-317(1), HO §14-316(c)(1), and HO §14-307(b), the Board notified the Applicant that there was reason to issue an initial denial of the application for reinstatement of licensure in that the Applicant failed to meet the requirements under the Act with regard to license reinstatements. The Applicant does not qualify for licensure in that he is not of good moral character.

The Applicant, on July 17, 1991, requested a hearing on the Intent to Deny. On August 15, 1991, Notice of the Hearing was sent to the Applicant advising him that a prehearing conference would be conducted on September 26, 1991 at 9:00 a.m., and the hearing would commence on October 2, 1991 at 9:00 a.m. The Applicant did not present himself for the prehearing conference. A subsequent letter was sent to him by the administrative prosecutor advising him that the time of the hearing would be changed from 9:00 a.m. on October 2, 1991 to 5:00 p.m. on October 2, 1991. No response was received from the Applicant, and, on October 2, 1991, the administrative law judge and the administrative prosecutor were present for the hearing at 5:00 p.m. Robert J. Gilbert, Esquire, the administrative prosecutor, advised the administrative law judge, at the time of the hearing, that he had placed a telephone call to the number given to him by the Applicant and was told that the Applicant was no longer in the jurisdiction. The Applicant did not present himself for the hearing. The hearing was conducted without the presence of the Applicant.

Summary of the evidence

The following documents were duly admitted into the record by the administrative prosecutor:

Exhibit A. Judgment, Probation, and Commitment Order from the United States District Court for the District of New Jersey.

Exhibit B. Copy of the Government of the District of Columbia Commission on Licensure to Practice the

Healing Art's Findings of Fact, Conclusions of Law, and Order to revoke the license of the Applicant, dated October 4, 1985.

Exhibit C. The state of Tennessee Department of Health and Environment Order of Summary Suspension, dated December 15, 1989.

Exhibit D. A Criminal Information issued by the state of Tennessee, Davidson County, Judgment and Docket entries evidencing a conviction for Medicaid fraud.

Exhibit E. The Notice of Intent to Deny Application for Reinstatement of Licensure under the Maryland Medical Practice Act issued on June 26, 1991.

As the Applicant did not appear, there was no evidence or testimony presented on his behalf.

There were no witnesses presented by the Board. The documents listed above comprised all of the evidence presented.

Findings of fact

A. The Board finds as follows:

1. The Applicant, Abdoul Edward Komeh, M.D., filed an application for reinstatement of licensure on June 20, 1990.
2. The Applicant was notified by the Board on June 26, 1991 that there was reason to issue an initial denial of the Applicant's application for reinstatement of licensure.
3. The Applicant was informed that a Final Order denying the application for reinstatement of licensure would be entered 30 days from the Applicant's receipt of the Board's Notice, unless the Applicant requested a hearing.
4. The Applicant received the Board's Notice of Intent to Deny, and on July 17, 1991, he requested a hearing.
5. The Applicant was notified of the date, time, and place of the prehearing conference and hearing by letter dated August 15, 1991.
6. The Applicant did not appear for the prehearing conference on September 26, 1991 at 9:00 a.m.
7. The administrative prosecutor advised the Applicant, by letter, that the time of the hearing had been changed from 9:00 a.m. to 5:00 p.m. on October 2, 1991.
8. The administrative prosecutor, having not heard from the Applicant, placed a call to him at the number given to him by the Applicant. The administrative prosecutor was told that the Applicant no longer resided in this jurisdiction.
9. The Applicant did not appear for the hearing on October 2, 1991 at 5:00 p.m.
10. The hearing was conducted without the presence of the Applicant.

B. The Board further finds

1. The Applicant was initially licensed to practice medicine by the Tennessee Board of Medical Examiners on or about March 20, 1979.

5. Section 1, Chapter 109, Acts 1988, effective July 1, 1988, recodified former HO §14-504(3) as HO §14-504(a)(3), and inserted the below italicized words in the existing statute: Is guilty of immoral or unprofessional conduct in the practice of medicine. Section 11, Chapter 6, Acts 1990, approved February 16, 1990, effective on or about January 1, 1991, renumbered HO §14-504(a)(3) as HO §14-404(a)(3).

Board of Physician Quality Assurance Actions

2. The Applicant was initially licensed to practice medicine in the state of Maryland on or about June 21, 1979. The Applicant's Maryland medical license lapsed for failure to renew on September 30, 1980.
3. The Applicant was initially licensed to practice medicine in the District of Columbia on or about June 17, 1981.
4. The Applicant's Tennessee medical license was automatically revoked in 1981 for failure to renew and to pay the annual license fee pursuant to *Tennessee Code Annotated* (TCA) 63-6-210(b).
5. On or about May 13, 1983, the Applicant, in the matter of *United States of America v Abdoul Edward Komeh, M.D.*, under docket number Cr. 82-00386(01), was convicted upon a plea of guilty in the United States District Court for the District of New Jersey, for the offense of conspiracy to commit fraud and bribery, a felony, in violation of Title 18, *United States Code*, Section 1343.

In this matter, it was alleged that the Applicant conspired to: (1) travel in interstate commerce with the intent to carry on the unlawful activity of bribing an employee of the National Board of Medical Examiners (NBME) in violation of the laws of the states of New Jersey and Pennsylvania; and (2) utilize interstate telephone calls to carry on a scheme to defraud the citizens of the United States and the NBME by obtaining advance test questions for examinations given by the NBME and distributing the questions to persons taking the examinations.

As a result of this conviction, the Applicant's sentence was imposed and suspended. The Applicant was placed on supervised probation for a period of three years, and was ordered to pay a fine of \$5000.00.

6. Pursuant to an Order dated October 4, 1985, the Commission on Licensure to Practice the Healing Art of the District of Columbia revoked the Applicant's license to practice medicine in the District of Columbia after finding that the Applicant violated *DC Code*, §2-1326(d)(2), in that the Applicant's

[C]onviction of conspiracy to commit fraud and bribery to illegally obtain prior access to standardized medical examinations administered throughout the country and to distribute those examinations (a violation of Title 18, *United States Code*, Section 1343, referred to above in section 5) has a direct bearing on whether he should be entrusted to serve the public as a licensed health care provider ... [the Applicant's] demonstrated disdain for the right of the public to be able to rely upon licensed health care providers to be competent practitioners evidences an attitude so callous to the health, safety and welfare of patients that ... [the Applicant] is not fit to practice medicine.

7. On or about September 2, 1986, the Applicant's Tennessee medical license was reinstated pursuant to TCA §63-6-210(c), upon receipt of a complete application and payment of licensing fees.
8. On or about December 15, 1989, the Tennessee Board of

Medical Examiners, pursuant to a document entitled "Order of Summary Suspension," summarily suspended the Applicant's license to practice medicine in Tennessee, finding that the "public health, safety, and welfare imperatively require emergency action to prevent ... [the Applicant] from continuing to practice medicine under a license obtained by fraud and deceit, from continuing malpractice in ... [the Applicant's] use of x-rays, and ... [the Applicant's] conviction of ... [a] felony involving conspiracy and fraud."

The findings of fact supporting the Order of Summary Suspension included findings that the Applicant: failed to renew his license to practice medicine in the states of Maryland and Tennessee in 1980 and 1981, respectively; was convicted, in federal court, on May 13, 1983 of conspiracy to commit fraud and bribery (described in section 5 above); made material misrepresentations to the Tennessee Board of Medical Examiners in 1985 and 1986 regarding his medical licensure status and criminal record in seeking reinstatement of his Tennessee medical license (resulting in the Tennessee Board of Medical Examiner's reliance on those averments in granting reinstatement of licensure); had his medical license revoked in 1985 in the District of Columbia by the Commission on Licensure to Practice the Healing Art of the District of Columbia (described in section 6 above); and engaged in fraudulent and/or inappropriate billing practices and inappropriate, excessive, or unauthorized utilization of radiologic equipment on patients in Tennessee on or about July 1987.

In summarily suspending the Applicant's medical license, the Tennessee Board of Medical Examiners found that the findings of fact contained in the Order of Summary Suspension were sufficient to establish that the Applicant violated the following provisions of TCA §63-6-214:

- a. Unprofessional, dishonorable, or unethical conduct. TCA §63-6-214(a)(1).
- b. Violation or attempted violation, directly or indirectly, or assisting in or abetting in the violation of, or conspiring to violate, any provision of this chapter or any lawful order of the Board issued pursuant thereto, or any criminal statute of the state of Tennessee. TCA §63-6-214(a)(2).
- c. Making false statements or representations, being guilty of fraud or deceit in obtaining admission to practice, or in being guilty of fraud or deceit in the practice of medicine. TCA §63-6-214(a)(3).
- d. Gross malpractice, or a pattern of continued or repeated malpractice, ignorance, negligence, or incompetence in the course of medical practice. TCA §63-6-214(a)(4).
- e. Conviction of a felony, conviction of any offense under state or federal drug laws, or conviction of any offense involving moral turpitude. TCA §63-6-214(a)(10).

In support of its decision to summarily suspend the Appli-

Board of Physician Quality Assurance Actions

cant's medical license, the Tennessee Board of Medical Examiners stated that

[The Applicant's] repeated acts of deceit and fraud have a direct bearing on his competency to practice medicine and to be entrusted to serve the public. [The Applicant's] demonstrated disdain for the right of the public to rely on their doctor to be competent and forthright evidences an attitude so callous to the health, safety, and welfare of patients that . . . [the Applicant] is not fit to practice medicine.

It is incumbent on all physicians to exercise the highest degree of professional care in performing x-rays on patients. The failure to do so can lead to harmful effects.

The public is entitled to entrust its health to physicians who show sound medical judgment and competency. A physician who is lacking in proper ethics, requisite medical judgement, and competency has the distinct propensity to harm his patients. It is the purpose and duty of the Board of Medical Examiners to protect the public from such physicians.

The conduct engaged in by . . . [the Applicant] cannot be tolerated by the Board of Medical Examiners and requires strict and swift action in order to protect the public health, safety, and welfare.

9. On or about January 11, 1990, the Tennessee Department of Health and Environment, pursuant to its authority under TCA §63-6-201 *et seq.*, charged the Applicant with disciplinary violations under TCA §63-6-214(a)(1), (2), (3), (4) and (10) (described in section 8 above). The allegations raised in this disciplinary action are pending at this time.
10. On or about October 5, 1990, the Applicant, in the matter of *State of Tennessee v Abdoul E. Komeh*, under criminal information number IF-5829, was convicted upon a plea of guilty in the Criminal Court of Davidson County, Tennessee, for the offense of obtaining money by false pretenses, a class E felony, in violation of TCA §39-14-103.

In this matter, it was alleged that the Applicant, during the period October 1987 through May 1989, pursuant to a single continuous larcenous scheme, obtained money by false pretenses by defrauding the Tennessee State Medicaid Program. As a result of this conviction, the Applicant was sentenced to a term of incarceration of one year, to be followed by a period of probation of one year, and was ordered to pay restitution in the amount of \$210,000.00 within two weeks of the date of the guilty plea.

11. The crime for which the Applicant was convicted in the United States District Court for the District of New Jersey on May 13, 1983, in the matter of *United States v Abdoul Edward Komeh, M.D.*, under docket number Cr. 82-00386(01), conspiracy to commit fraud and bribery, is a crime involving moral turpitude.
12. The crime for which the Applicant was convicted in the

Criminal Court of Davidson County, Tennessee, on October 5, 1990, in the matter of *State of Tennessee v Abdoul E. Komeh*, under criminal information number IF-5829, obtaining money under false pretenses, is a crime involving moral turpitude.

13. In Maryland, the act of making material misrepresentations in seeking reinstatement of medical licensure would be grounds for disciplinary action under the Act under HO §14-404(a)(1) and HO §14-404(a)(11).
14. In Maryland, conviction for defrauding a state Medicaid program would be grounds for disciplinary action under the Act under HO §14-404(a)(11), HO §14-404(a)(21) (with underlying grounds under HO §14-404(a)(3) and HO §14-404(a)(11) and HO §14-404(b).
15. In Maryland, conviction for conspiracy to commit fraud and bribery would be grounds for disciplinary action under the Act under HO §14-404(a)(21) (with underlying grounds under HO §14-404(b)), and HO §14-404(b).
16. In Maryland, the act of engaging in fraudulent and/or inappropriate billing practices would be grounds for disciplinary action under the Act under HO §14-404(a)(11).
17. In Maryland, the acts of being revoked by the Commission on Licensure to Practice the Healing Art of the District of Columbia and of being suspended by the Tennessee Board of Medical Examiners would be grounds for disciplinary action under the Act under HO §14-404(a)(1), HO §14-404(a)(11), HO §14-404(a)(21) (with underlying grounds under §14-404(a)(21) and §14-404(b)), and HO §14-404(b).
18. The Board has been charged with the responsibility of regulating the practice of medicine in the state of Maryland. HO §14-101 *et seq.* As such, the Board is empowered with the authority to assess both the competence and the moral character of those individuals who seek licensure, renewal, or reinstatement of medical licensure in Maryland. In order to be considered for reinstatement of licensure, a physician shall be of good moral character. [HO §14-317(1), HO §14-316(C)(1) and HO §14-307(b).] In assessing good moral character, the Board attempts to make a determination of the physician/applicant's integrity, trustworthiness, credibility, and reputation for honesty.

In making the determination of whether the physician/applicant possesses good moral character, the Board evaluates the physician/applicant's background in general and, specifically, with regard to his actions within the medical community. Such considerations as: the physician/applicant's criminal record, particularly as it relates to the practice of medicine; his truthfulness in disclosing details of his background when so requested by state licensing agencies; his prior relationship to the medical community, including any prior medical licensure and disciplinary actions previously

Board of Physician Quality Assurance Actions

taken against him by a state medical licensing agency; and integrity in the practice of medicine are all relevant factors in the Board's determination of good moral character.

The Applicant has been convicted, both in federal court in 1983 and in Tennessee state court in 1990, of actions clearly amounting to crimes involving moral turpitude. These convictions, which were based on fraud, deceit, and false pretenses, all of which involve the medical community and the practice of medicine, are reflective on any determination of the quality of the Applicant's moral character. Furthermore, the District of Columbia government revoked the Applicant's license to practice medicine in the District of Columbia for the aforementioned federal felony fraud conviction. In addition, the Applicant had been summarily suspended by the Tennessee Board of Medical Examiners after it found that the Applicant engaged in: unprofessional, dishonorable, or unethical conduct; making false statements or representations in obtaining admission to practice or in being guilty of fraud or deceit in the practice of medicine; gross malpractice, or a pattern of continued or repeated malpractice, ignorance, negligence or incompetence in the course of medical practice; and in being convicted of a felony and/or offense involving moral turpitude.

The Applicant's convictions for crimes involving moral turpitude, coupled with the disciplinary actions taken against him by the licensing authorities of the District of Columbia and Tennessee, all clearly indicate well-defined instances of fraud, deceit, unprofessional conduct, lack of integrity, and a lack of good moral character. This series of criminal convictions and disciplinary sanctions collectively establish that the Applicant does not possess the good moral character required for medical licensure in the state of Maryland.

Conclusions of law

Based on the foregoing Findings of Fact, the Board concludes as a matter of law under HO §14-205 that the Applicant has committed the following prohibited acts under HO §14-404. They include the following:

1. The Applicant fraudulently and/or deceptively obtained a license to practice medicine, under HO §14-404(a)(1);
2. The Applicant willfully made or filed a false report or record in the practice of medicine, under HO §14-404(a)(11);
3. The Applicant was disciplined by a licensing or disciplinary authority or disciplined by a court of any state ... for an act that would be grounds for disciplinary action under this section, under HO §14-404(a)(21). The underlying grounds actionable under this section include the following:

Fraudulently or deceptively obtains or attempts to obtain a license for the applicant ...; [HO §14-404(a)(1)].

Is guilty of immoral or unprofessional conduct in the practice of medicine; [HO §14-404(a)(3)].

Willfully makes or files a false report or record in the practice of medicine; [HO §14-404(a)(11)].

Is disciplined by a licensing or disciplinary authority or disciplined by a court of any state ... for an act that would be grounds for disciplinary action under this section; [HO §14-404(a)(21)].

4. The Applicant was convicted of crimes involving moral turpitude, under HO §14-404(b).

Furthermore, the Board has determined that the Applicant has failed to meet the requirements under HO §14-317(1), HO §14-316(c)(1), and HO §14-307(b) with regard to license reinstatements insofar as the Applicant is not of good moral character.

Order

After reviewing the application of Abdoul Edward Komeh, M.D., former license number D23626, for reinstatement of medical licensure, it is this 27th day of November, 1991, by an affirmative vote of a majority of the full authorized membership of those members of the Board of Physician Quality Assurance who considered this case,

ORDERED that the application of Abdoul Edward Komeh, M.D. for reinstatement of his license to practice medicine in the state of Maryland is DENIED; and be it further

ORDERED that this is a FINAL ORDER and as such will be considered a public document pursuant to *Md. State Gov't. Code Ann.* §10-611 *et seq.*

ISRAEL H. WEINER MD, Chairperson
Maryland Board of Physician Quality Assurance



In the matter of
Waheeda S. Qaiyumi, M.D.
before the
Maryland Board of
Physician Quality Assurance

Amended final order reinstating license

By Final Decision dated November 6, 1989, the Board of Physician Quality Assurance (the Board) voted to revoke the license of Waheeda S. Qaiyumi, M.D. (the Respondent). The Final Decision stated that on or after October 1, 1990, Respondent could petition the Board for reinstatement of her license but that in no event would the Respondent's license be reinstated prior to November 27, 1990. Respondent petitioned the Board through its Settlement Conference for reinstatement of her license on December 5, 1990.

Board of Physician Quality Assurance Actions

At its meeting on December 12, 1990, the Board considered the Settlement Conference's recommendation and voted to amend its Final Order. By Order dated December 21, 1990, the Board ordered that it would not consider the petition for reinstatement from Respondent until such time as Respondent submits evidence of successfully completing certain conditions. The Order provided that in the event that the Board stays the revocation of Respondent's license and thus reinstates the Respondent's license, the Board can impose any additional reasonable conditions of probation. After having received necessary documentation indicating that the Respondent had successfully completed those conditions imposed by the Amended Final Order, at its meeting on August 28, 1991, the Board's Case Resolution Conference (Conference) decided that the Respondent had successfully fulfilled the conditions contained in the December 21, 1990 Order.¹

Findings of fact

1. The Respondent provided documentation that she had completed all continuing medical education requirements for three years preceding the time of the petition for reinstatement;
2. The Respondent submitted evidence of having completed continuing medical education courses in medical billing;
3. The Respondent took and passed the June 1991 Special Purpose Examination (SPEX) of the Federation of State Medical Boards; and
4. On August 13, 1991, the Respondent was evaluated by Frank A. Oski, M.D., professor, Department of Pediatrics, Johns Hopkins Hospital. In his evaluation report to the Board, Dr. Oski stated that he found the Respondent to be medically qualified to return to the practice of pediatric medicine in the state of Maryland.

Conclusions of law

The Board incorporates by reference the conclusions of law contained in its Amended Final Decision of December 21, 1991 and further concludes that Respondent's license is REINSTATED subject to certain conditions of probation.

Order

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 12th day of September 1991, by the Board, hereby:

ORDERED that Respondent's license to practice medicine in the state of Maryland be REINSTATED; and be it further

ORDERED that the Respondent shall submit to a peer

review of her practice on a biannual basis for a period of three years from the effective date of this Order. The first review is to be performed on or about March 1, 1992. If the Board should receive a peer review report indicating that Respondent is failing to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care under §14-404(a) (22) of the Act, the Board MAY VACATE THE STAY OF REVOCATION, provided that Respondent is given notice of the Board's action and an opportunity for a hearing within 30 days after the Respondent requests a hearing; and be it further

ORDERED that, three years after the effective date of the Order, that being the date on which the Board signs the Order, Respondent may petition the Board for termination of probation and reinstatement of her license without any conditions or restrictions; and be it further

ORDERED that this Order is considered a public document pursuant to the Maryland Public Information Article, *Maryland State Government Code Annotated*, §§10-611 *et seq.*, specifically §10-617(h)(2)(vi).

ISRAEL H. WEINER MD, Chairperson
Maryland Board of Physician Quality Assurance

Consent

By signing this Order, I hereby accept and agree to be bound by the foregoing Order and its conditions and restrictions consisting of five pages.

1. I acknowledge the validity of this Amended Final Order and the legal authority of the Board of Physician Quality Assurance to issue and enforce this Order.
2. I, Waheeda S. Qaiyumi, M.D., have read this Consent Order and have carefully reviewed each and every part with my attorney, David S. Harvis, Esquire. I understand it and voluntarily agree to it.
3. I sign and consent to this Order after having an opportunity to consult with counsel and with full understanding of the meaning and the terms of the Order.

WAHEEDA S. QAIYUMI, M.D. ■

■ ■ ■
In the matter of
Gregory R. Valcourt, C.R.T.
before the
Maryland Board of
Physician Quality Assurance

Order terminating probation and reinstating
certification

By Order dated October 24, 1990 (the 1990 Order), the Board of Physician Quality Assurance (the Board) found Gregory R. Valcourt (the Respondent), Cardiac Rescue

1. At its meeting on June 26, 1991, the Board delegated to the Conference the responsibility of reviewing and evaluating petitions for reinstatement of license. If the Conference determines that all conditions have been met, the petitioner's license will be reinstated upon the Board chairperson's execution of an order reinstating the license.

Board of Physician Quality Assurance Actions

Technician (C.R.T.), guilty of committing prohibited acts as set forth under *Md. Health Occ. Code Ann.* §14-303(c). The Board charged Respondent under COMAR 10.31.06.02.A.(9) which states "Fraudulent or deceitful procurement or use of a certification." The Board further charged Respondent under the provisions in COMAR 10.32.06, which state, "A cardiac rescue technician may be de-certified if he fails to meet the annual performance re-certification requirements set forth in Regulation .09. See COMAR 10.32.06.11.A." The Board revoked Respondent's certification to practice as a C.R.T. and stayed the revocation, conditioned upon the Respondent complying with conditions of probation (the Conditions of Probation). The Order further provided that after August 6, 1991, but not later than September 6, 1991, if the Respondent demonstrated to the Board's satisfaction that Respondent had complied with the terms and conditions of his probation, the Board would entertain a petition for altering the terms of Respondent's probationary status.

By letter dated August 1, 1991, Respondent petitioned the Board for Termination of Probationary Status and Reinstatement of his Certification (Petition) to practice medicine in Maryland. At its meeting on September 11, 1991, the Board, through its Case Resolution Conference (the Conference), reviewed Respondent's Petition.¹ Based upon the Board's review of the Petition, the Board determined that Respondent had fulfilled the Conditions of Probation contained in the 1990 Order.

Findings of fact

Based on the information known and available to it, the Board finds that:

1. Respondent has not practiced as a C.R.T. since July 25, 1991, and does not intend to practice as a C.R.T. until the Board reinstates him.
 2. By letter dated October 24, 1991 and received by the Board on October 25, 1991, Respondent requested
1. At its meeting on June 26, 1991, the Board delegated to the conference the responsibility of reviewing and evaluating petitions for reinstatement of licenses without probationary conditions. If the Conference determines that all probationary conditions have been met, the petitioner's license will be reinstated without conditions upon the Board Chairperson's execution of an Order terminating the conditions.

George S. Everly, Jr., Ph.D. be approved as his psychologist. By letter dated December 10, 1991, the Board approved Dr. Everly as Respondent's psychologist. The visits with Dr. Everly were scheduled on a weekly, and later, on a biweekly basis. In his final report dated July 19, 1991, Dr. Everly wrote that Respondent had successfully completed the psychotherapy and that Respondent should be allowed to practice as a C.R.T.

3. The releases, permitting the therapist to report to the Board, were received by the Board on July 23, 1991.
4. Respondent successfully completed the "Introduction to Ethics" course given during the spring semester of 1991 at Howard Community College.
5. Respondent has met the certification requirements to practice as a C.R.T.
6. Respondent met with Robert A. Lessey, M.D. for an evaluation on July 30, 1991. Dr. Lessey recommends that Respondent be permitted to return to practice as a C.R.T.

Conclusions of law

The Board concludes, as a matter of law, that Respondent has satisfactorily complied with all conditions of probation as set forth in the 1990 Order.

Order

Upon the foregoing Findings of Fact and Conclusions of Law, it is, this 24th day of September 1991, by a majority vote of the full authorized membership of the Board

ORDERED that effective as of the date of this Order, the Conditions of Probation imposed upon Respondent's practice of medicine by the Board's 1990 Order are hereby TERMINATED and of no further force and effect; and be it further

ORDERED that Respondent's license to practice medicine in the State of Maryland be REINSTATED without any condition or restriction whatsoever; and be it further

ORDERED that this is a Final Order and as such is considered a public document pursuant to the Maryland Public Information Article, State Government Article, *Annotated Code of Maryland*, §§10-611 *et seq.*, specifically §10-617(h)(2)(vi).

ISRAEL H. WEINER MD, Chairperson
Maryland Board of Physician Quality Assurance

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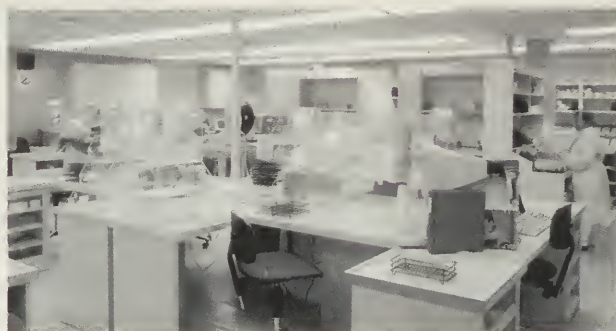
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Epidemiology & Disease Control Program

EPIDEMIOLOGY & DISEASE CONTROL PROGRAM

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Update: *Salmonella enteritidis* associated with shell eggs

February, 1992

In previous articles in the Maryland Medical Journal we have reviewed the problem of Salmonella enteritidis associated with shell eggs. Cases and outbreaks continue to occur. Health care professionals need to be aware of the association between the consumption of raw or under-cooked eggs or egg-containing foods and gastroenteritis, especially in high risk individuals.

Introduction

From 1976 through 1985, the mid-Atlantic and north-east regions of the United States experienced a five-fold increase in reported isolates of *Salmonella enteritidis* (SE)^{1,2}. Since 1985, this increase has continued and has spread to other parts of the country (Figure 1).³ Initially egg-associated outbreaks were thought to be due to external contamination of shells;¹ however, recent evidence suggests that internal contamination via trans-

ovarian transmission is the predominant mechanism leading to SE infected eggs.⁴

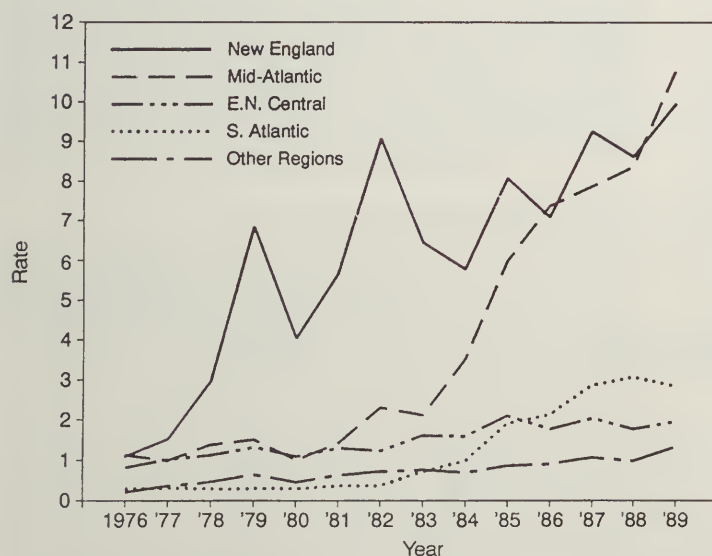
In Maryland, from January, 1987, through November, 1991, SE was the most common serotype of *Salmonella*, accounting for 25-37% of serotyped isolates annually (Figure 2). While reported cases of salmonellosis have declined during this period, SE outbreaks continue to occur (Table 1). Between January, 1987 and December, 1991, 91 outbreaks of salmonellosis were reported in Maryland, 45 (49%) of which were caused by SE. Forty percent (18 of 45) of these SE outbreaks were associated with shell eggs or egg-containing foods. Egg-associated outbreaks have been a significant source of morbidity, with a 12% (40/343) hospitalization rate among affected individuals. No deaths occurred from the SE outbreaks.

This report summarizes four egg-associated outbreaks that occurred in Maryland which illustrate key issues relevant to the prevention of morbidity associated with this mode of SE transmission.

Outbreak A

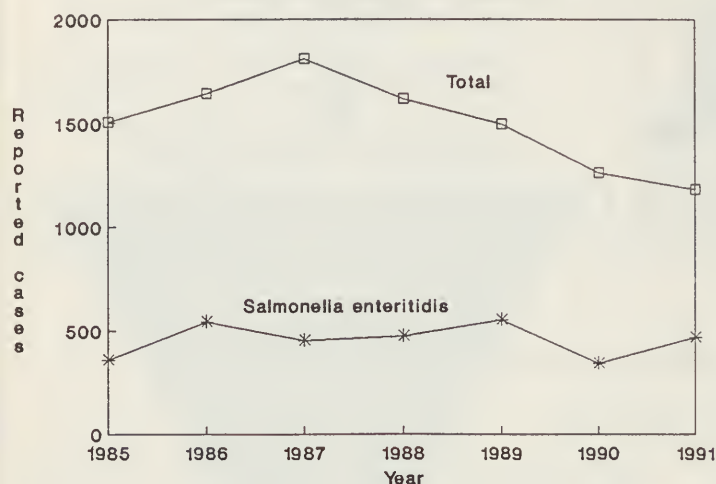
Fifteen patrons developed gastroenteritis (GE) after eating at restaurant A during an 18 day period. Further investigation revealed that seven employees had a similar illness during the same period. The predominant symptoms were diarrhea (82%), nausea (54%), and fever (50%). Median incubation was 24 hours (range 5-128 hours); median duration of illness was eight days (range 1-30 days). Eleven patrons sought medical care and two were hospitalized. None of the employees sought medical care. SE was isolated from the stool of 11 ill patrons, two of seven ill employees, and six of 41 employees who did not report illness.

Figure 1. Isolation rate* of *Salmonella enteritidis*, by region--
United States, 1976-1989



* Per 100,000 population.

Figure 2. Reported cases of *Salmonella* and *S. enteritidis*--
Maryland, 1985-November, 1991.



Eleven of 15 ill patrons consumed lightly cooked whole eggs (eggs "over easy") or dishes prepared with pooled eggs. Only two of 13 employees (7 ill and 6 asymptomatic with SE in stool) had a similar food history.

Eggs were delivered twice per week at ambient temperature by an unrefrigerated truck and stored at room temperature until use. Eggs were pooled by mixing 270 hand-cracked eggs with one-half gallon of cold water. This mixture was then refrigerated until use. Small quantities of pooled eggs were temporarily kept in a metal pan adjacent to the grill prior to cooking. During inspection the pool mixture in this pan was found to be 60°F, well above the recommended $\leq 45^\circ\text{F}$. Occasionally, eggs from new and old pools were combined in this pan. Cultures of pooled eggs taken from both the walk-in refrigerator and the grill-side storage pan yielded fecal coliforms (1500 and 2900 organisms/100 gm, respectively), but no *Salmonella*.

Outbreak B

Fifteen patrons from six parties developed GE after eating at restaurant B during an eight day period. Predominant symptoms were diarrhea (100%), fever (92%), abdominal cramping (92%), and nausea

(92%). The median incubation period was 24 hours (range 12-48 hours); median duration of illness was seven days (range 4-10 days). Thirteen cases sought medical care, eight required intravenous rehydration, and six were hospitalized. *Salmonella* group D was isolated from the stool of 13 of the ill patrons; eight of these 13 were confirmed as SE. Fourteen of 15 cases ate Caesar salad; none of the 11 well individuals who ate in these parties ate Caesar salad ($p < 0.0001$).

Further investigation revealed that 32% (25/77) of employees reported symptoms consistent with GE during the period of the outbreak. Predominant symptoms were diarrhea (88%), abdominal cramps (72%), and fever (56%). Median date of onset was the same for both employees and patrons. Median duration of illness was five days among employees (range 1-10). Only two employees sought medical care; none were hospitalized.

Sixteen (64%) of the 25 ill employees had SE isolated from stool specimens. Four of the 52 employees with no reported illness had SE isolated from their stool. Three of four employees who reported eating Caesar salad during the outbreak were confirmed SE cases; however, the majority of confirmed employee cases (19/22) did not report eating this dish. Consumption of any of the restaurant's raw shell egg-containing dishes was not a risk factor for SE infection among employees (relative risk 0.84; 95% CI: 0.59-1.21).

Caesar salad dressing was prepared early in the morning by combining yolks from hand-cracked eggs with olive oil, anchovies, garlic, and warm water. The dressing was stored in a refrigerator until the restaurant opened, when it was placed in a "refrigerated" salad prep area until it was exhausted or the restaurant closed. By the time of inspection, Caesar salad had been eliminated from the menu by the restaurant management. However, during inspection other salad dressings in this preparation area were found to be 60°F. Culture of a test batch of Caesar salad dressing prepared during the inspection did not yield *Salmonella*.

Table 2. Reported Outbreaks of Salmonellosis, Maryland, January, 1987-November, 1991.

Year	Salmonella Outbreaks (all serotypes)	<i>S. enteritidis</i> (SE) Outbreaks	Egg-associated SE Outbreaks*	In Egg-associated SE Outbreaks		
				Persons Ill	Culture Confirmed	Hosp.
1987	17	7	1	10	9	5
1988	20	8	4	70	40	15
1989	15	10	3	74	33	0
1990	23	15	7	119	60	7
1991	16	5	3	70	55	10
Total	91	45	18	343	197	40

*Includes SE outbreaks with either probable or definite egg association

Eggs were received twice per week and stored in a walk-in refrigerator until use. Eggs from the shipment implicated in the outbreak were not available at the time of inspection; three cases of eggs delivered subsequently from the same farm were available for testing. Six pools of ten eggs each were sampled from these cases and submitted for culture. SE was isolated from one of the pools.

Outbreak C

Eleven preschool-age children developed symptoms of GE after consuming a banana milkshake prepared by a teacher at a day care center. No children were hospitalized. Eighteen children and three adults each consumed an average one-to-two ounces of the milkshake. Eight of the children's stool cultures yielded SE, two of whom were asymptomatic.

The teacher prepared the milkshake by mixing pasteurized skim milk with commercially prepared vanilla ice cream, one banana, and one raw shell egg in a clean blender. It was served and consumed immediately after preparation. Ingredients, including one carton of grade A extra large eggs, had been purchased on the morning of preparation and were stored in a refrigerator for approximately two hours until the time of preparation. The teacher was the only individual involved in preparation of the milkshake. The teacher had no symptoms of GE; both stool specimens submitted for culture were negative. Neither the milkshake nor its ingredients were available for culture at the time of investigation.

Outbreak D

Nineteen students and three teachers developed GE after consuming homemade ice cream prepared in a school classroom. Predominant symptoms were diarrhea (100%), abdominal pain (87%), fever (87%), headache (63%), and nausea (59%). Mean incubation was 20 hours (range 4-67 hours) and mean duration was eight days (range 3-12 days). Thirteen cases sought medical care, five required intravenous rehydration, and two were hospitalized. All 22 cases were confirmed by isolation of *Salmonella* group D or SE. None of the 21 students who did not eat the ice cream was ill.

Ingredients were purchased on the morning the ice cream was prepared. They were stored in a refrigerator for several hours prior to preparation. Six hand-cracked shell eggs were mixed with milk and sugar and then were cooked over low heat for 10-15 minutes until the mixture thickened. It was removed from heat and cooled for 10 minutes, then the remaining ingredients (whipping cream and vanilla extract) were added. This mixture was then cooled 10 minutes in the refrigerator, after which it was poured into the cold ice cream maker and stirred for 35 minutes. The ice cream was then placed in a freezer for one hour prior to being served to one class. It was then returned to the freezer until being served the next class. Both classes had cases of SE.

Egg Tracing

In outbreaks A, C, and D, SE was isolated from the layer flocks which produced the eggs associated with the outbreaks. Phage types of SE isolates from the implicated flocks were identical to that of cases in each of these three outbreaks. In outbreak B, the flock identified as the source of SE infected eggs had been depopulated by farm management due to aging of the layer hens prior to its identification by the United States Department of Agriculture (USDA); therefore, this layer flock was not cultured.

Comment

These outbreaks highlight several critical issues in the epidemiology and prevention of morbidity from *Salmonella*.

Common food handling errors identified in egg-associated SE outbreaks include use of raw shell eggs in recipes, pooling many eggs together prior to cooking, holding eggs or egg-containing foods at temperatures that allow multiplication of organisms, and inadequate duration or intensity of cooking so that temperatures sufficient to kill SE are not reached.⁵ Restaurant A contributed to the outbreak by failing to purchase and store eggs under refrigeration, pooling large numbers of eggs, allowing pooled eggs to sit at incubating temperatures, and cross-contaminating egg pools by mixing new egg pools with prior pools before cooking. Restaurant B served a product containing pooled raw egg yolks and allowed that product to sit at incubating temperatures for prolonged periods of time.

Outbreaks A and B also demonstrate the high attack rates among employees (27% and 39%, respectively) during *Salmonella* outbreaks and the relative frequency with which employees who report no symptoms are found to harbor SE during the course of an outbreak (17% and 10%, respectively). This finding underscores the importance of screening all potential foodhandlers in the setting of an outbreak.

The greater severity of illness seen in patrons may be attributable to reporting bias. Patrons with mild or asymptomatic infection are less likely to be reported during an outbreak investigation. Patrons with mild symptoms may not report illness to their local health department, may not pursue medical evaluation, or may not associate their illness with food or drink consumed several meals prior to the onset of symptoms.

Both outbreaks A and B revealed that the food item implicated as causing patron illness was not substantially associated with risk of illness among employees.

The risk of using even small quantities of raw shell eggs in non-food service settings is demonstrated by outbreak C, which was associated with consumption of a single raw egg in a recipe prepared and served in the absence of other food handling errors. The high attack

rate and severity of illness should serve as caution to anyone contemplating preparation of a raw egg-containing food (e.g., homemade eggnog, homemade mayonnaise, mousses, uncooked cake or cookie batter, merengue, some cake icings).

Outbreaks A and D were associated with partially cooked eggs. Recipes which call for partially cooked eggs (e.g., lightly cooked custards, hollandaise or bear-naise sauce, eggs "over easy") should be considered risky because partial cooking may not be sufficient to destroy all the organisms in an infected egg.⁴⁻⁶

Another food item that has been frequently implicated in SE outbreaks in the United States is crabcakes or other fried seafood cakes. The recipes for these foods include raw eggs. Since such cakes contain previously cooked crab meat or other seafood, they should be brought to 165°F. However, frying is often stopped when the outside reaches the desired brownness. The center of the crabcake or fish cake is insulated from the fryer's heat and, thus, is frequently inadequately cooked.

The USDA instituted regulations in 1990 permitting investigation of flocks which have been epidemiologically implicated in SE outbreaks. Flocks which are found to be infected with SE are restricted from sale of fresh eggs; the flocks are either destroyed or their eggs are diverted to pasteurization. To facilitate tracing of eggs in SE outbreaks, each case of eggs purchased by a retailer or food service establishment is accompanied by a packing slip identifying the flock which produced the eggs. To facilitate egg tracing, Maryland regulations require purchasers to retain these packing slips in their records for 90 days. In each of the outbreaks reported above, the responsible restaurateur or retailer had not maintained such records. This failure delayed and complicated egg tracing efforts. However, using shipping invoices, each of the layer flocks responsible for generating the implicated eggs was eventually identified.

Recommendations

Physicians can be a primary source of counseling on safe food-handling for their patients. They also have access to the populations most susceptible to severe illness resulting from SE gastroenteritis: infants, adults over age 65, and immunocompromised patients.

The following recommendations are proposed to consumers in the light of these and other egg-associated SE outbreaks:⁷

1. Consuming raw or partially cooked eggs or egg-containing foods is strongly discouraged and particularly ill-advised in the aforementioned high-risk groups. Pasteurized eggs are a safe alternative to shell eggs. No outbreaks of SE have been associated with pasteurized eggs.
2. Thorough cooking kills *Salmonella* and is achieved only when yolks or pools are no longer liquid or moist. Serve cooked eggs and egg-containing recipes

immediately after preparation or refrigerate promptly. Discard egg leftovers if not consumed within three days, even if they have been refrigerated.

3. Pooling of eggs is strongly discouraged. If recipes call for pooled eggs, pasteurized eggs are recommended. When shell eggs are pooled, pools should be as small as possible and the eggs used should be $\leq 45^{\circ}\text{F}$ just prior to pooling and must be maintained at that temperature after pooling until cooked.
4. When refrigerating a large amount of an egg containing food, divide it into several shallow containers so that it will cool quickly.
5. Use grade A or AA eggs. Eggs should be purchased only if refrigerated and then should be maintained at $\leq 45^{\circ}\text{F}$ during storage. Eggs, cooked or uncooked, should be discarded if they have been out of refrigeration for more than two hours.
6. Exercise caution when selecting food items from restaurant menus--when in doubt, ask if the food contains raw or under cooked eggs.

All physicians and laboratories are required to report evidence of *Salmonella* infection to their local health department within 48 hours of diagnosis or isolation.⁸ Confirmed and suspected outbreaks are immediately reportable. Rapid reporting facilitates health department investigation.

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TOUGH, SMART AND YOURS

medical
economics

Successfully defending a brain-damaged baby case is the courtroom equivalent of pitching a no-hitter. Because the "sympathy factor" can add millions to a jury's award, many insurance carriers would rather settle than fight.

Not so the P-I-E Mutual Insurance Co. of Cleveland, Ohio, and the 1-year-old law firm—Maynard, Tuschman & Kalur—that does all its defense work. In 21 brain-damaged baby cases it has defended for the doctor-owned company, its record is remarkable. 10-1-1, the last a hung jury. In 1988, its overall record read 33 wins, 3 losses—all malpractice cases.

There's more to these numbers than luck "It's even legal skill," adds JMT&K founding partner Aaron Jacobson, who was one of Ohio's leading plaintiffs' lawyers before he, Larry E. Rogers, Herbert S. Bell, M.D., and 70 other Cleveland doctors formed P-I-E in 1975.

"It's the concept behind the firm that makes it work. Physicians specialty panels review every lawsuit to decide whether the defendant deviated significantly from the standard of care. If he did, we pay. If he didn't, we defend. Makes no difference whether it's a \$5,000 or a \$5-million case. We label it 'No pay.' That policy has resulted in a lot of cases being dropped. Perhaps more important, it's

DON'T YOU WISH THESE DEFENSE LAWYERS WERE YOURS?

This big, multistate firm rarely loses a case. But it's more than luck, or even legal skill, that's behind its enviable record.

By Howard Eisenberg

discouraged the filing of many other cases. Plaintiffs' attorneys have learned that we're fair negotiators when our doctor's in the wrong, but won't back down when he's right."

That approach pays off. "According to the most recent report I've seen from the General Accounting Office," says Larry Rogers, P-I-E president and CEO, "in 1984, about 37 percent of medical-malpractice claims were closed without payment."

Through 1988, we've closed an average of 78 percent of our cases without a dime changing hands. And it's my understanding that, without including defense costs, St. Paul Fire and Marine Insurance Co.'s 1988 average gross payout for cases closed in Ohio with payment was \$32,500. Our comparable figure was about \$10,000 below

theirs. That's partly why we can sell an OHG specialist in Ohio—an industrial state that ranks among the most litigious—\$12 million in coverage for just \$20,000."

The unique marriage of P-I-E and JMT&K has been so successful that the carrier has expanded into five other states: Indiana, Kentucky, Maryland, Missouri, and West Virginia. Where P-I-E goes, there goes JMT&K, with one branch of medical-malpractice defense attorneys exclusively to medical-malpractice defense.

Could the insurer-defender symbiosis, if duplicated by other doctor companies, make a significant contribution to reducing malpractice litigation nationwide? An up-close look at

how JMT&K operates may help to answer that question.

Every lawyer develops a medical specialty

"Our firm's lawyers read more medical books than law books," says P-I-E Vice President Gerard C. Uppenorth, himself a veteran defense attorney. Robert Maynard explains: "New cases are discussed at our weekly staff meeting, so that every lawyer is familiar with every case. But we assign cases to our attorneys according to medical specialty. They're well-versed in their fields, so they don't have to re-invent the wheel with each case."

Last year, the firm's OHG specialist, attorney Jerome S. Kalur, who had won 16 consecutive brain-damaged baby cases, faced one of his toughest challenges when he defended a girl

who'd attempted a malpractice delivery that ended in a Caesarian section and a severely brain-injured baby. Recalls Kalur: "I didn't think the doctor had caused the damage, but our position was weakened by the fact that he didn't have malpractice privileges. Based on that departure from the standard of care, our doctor panel voted to settle, and, since the hospital was also involved, a combined sum of \$1.5 million was offered. Plaintiff turned us down flat."

"I wanted to depose the doctor, who'd been involved in the mother's care during her hospitalization, but the attorney for the plaintiff baby insisted it would violate the mother's physician-patient confidentiality. That privilege would terminate automatically when her medical

The winning firm's four founders at Cleveland's 8th District Court of Appeals (from left): Jerome S. Kalur, Aaron Jacobson, James M. Tuschman, and Robert Maynard.

records were introduced at the trial end of the plaintiff's case. Meanwhile, I was in the moon position of having to tell the jury: 'It couldn't have been the malpractice,' without offering them another reasonable brain-damage theory."

Fortunately, the plaintiffs rested their case on a Friday afternoon, giving JMT&K time for a weekend rally. "Twenty minutes later," says Kalur, "I was in the hospital pathologist's office with an order permitting me to view the mother's placental slides." Meconium staining had been charted, and Kalur had a hunch that fetal distress had begun long before the bir



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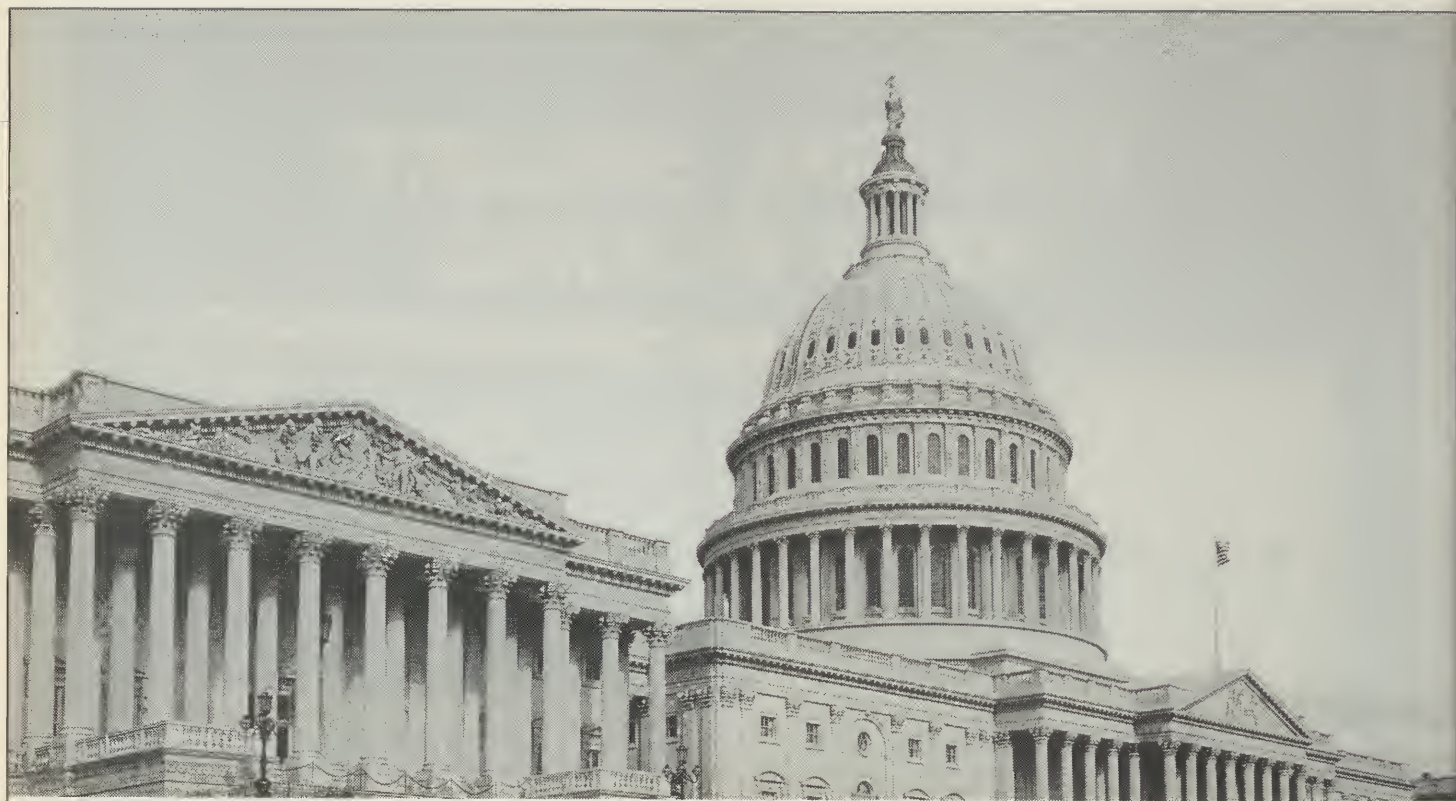


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Jane Avery Fiscus, M.D. recently received the Western Maryland Area Health Education Center (AHEC) Annual Award for Distinguished Service to Health Care in Western Maryland. V. Raul Felipa, M.D., Chairperson of the Western Maryland AHEC Medical Caucus, presented the award to Dr. Fiscus "in recognition of her insightful, resourceful, and dedicated leadership and support of interdisciplinary health professional education in western Maryland." She also received a certificate of faculty appointment as associate professor of clinical medicine at the University of Maryland for her work as a preceptor for medical students and residents in AHEC's Clinical Education Program.



As health officer for the Allegany County Health Department since 1978, she has been responsible for many programs including an adult addiction rehabilitation center; an adolescent residential shelter and treatment unit; and an AIDS prevention, testing, and education program. She began her professional career as a clinical consultant with the Montgomery County Health Department working in the children's clinic, the school health program, the tuberculosis clinic, and the venereal disease clinic. In 1967, she was appointed director of Child Mental Health Services. Dr. Fiscus has also worked as a private family practitioner in West Virginia, and as a geriatric consultant and medical director for the Lions Manor Nursing Home.

A graduate of Oklahoma State University and Baylor University College of Medicine, where she also completed graduate studies in biochemistry, Dr. Fiscus did residency work in internal medicine at Duke University and was awarded a postdoctoral fellowship at Baylor.

Robert M. Heyssel, M.D., president of the Johns Hopkins Hospital and the Johns Hopkins Health System, was honored by the German Society of Maryland with its 1991 award for service to the German community of Maryland. Proceeds from the ceremony on November 8, which was attended by

Ambassador Jurgen Ruhfus of the Federal Republic of Germany, will go to the society's scholarship fund.

A graduate of the University of Missouri School of Medicine and St. Louis University, Dr. Heyssel has received numerous academic awards and distinctions including the U.S. Public Health Service Career Development Award, a Distinguished Alumnus Award from the University of Missouri, and Sc.D. honors from St. Louis University. Dr. Heyssel began his teaching career in 1959 as an instructor at the Vanderbilt University School of Medicine in Nashville, Tennessee. Since that time, he has published a myriad of articles on hematology, the role of medical schools, and the health care marketplace. His credentials include an impressive list of public service activities, and memberships in many professional and learned societies. Dr. Heyssel is married and has five children.



Carol Johnson Johns, M.D., associate professor of medicine and assistant dean and director of continuing education at the Johns Hopkins University School of Medicine, was recently awarded the American Lung Association of Maryland's (ALAM) George Wills Comstock, M.D. Award. She received this award in recognition of her extraordinary lifetime service to the ALAM's

goals of promoting respiratory health through care, teaching, and research.

Dr. Johns is a graduate of Wellesley College (honors chemistry) and the Johns Hopkins University School of Medicine. In 1974, she was cited as Medical Woman of the Year by the Medical College of Pennsylvania. A prolific author, Dr. Johns has been associated with Johns Hopkins since 1953. She is married to Richard J. Johns, M.D., and has three children.



John O. Meyerhoff, M.D., an assistant professor of medicine for the Division of Rheumatology and Clinical Immunology at the University of Maryland School of Medicine, was recently awarded the 1991 Community Service Award by the Baltimore City Medical Society (BCMS) for his special contributions to Parents Anonymous of Maryland. Having served as chairperson of its board of directors since 1986, Dr. Meyerhoff has led the agency's drive to strengthen families and prevent child abuse and neglect throughout Maryland. He helped develop educational programs that successfully increased public awareness and understanding of child abuse and its negative effect on society. His determination to prevent adolescents from dropping out of school, becoming pregnant, or turning to drugs or crime, resulted in the formation of many innovative programs, the most recent of which enables young, troubled teens to receive needed services at 20 city and county schools. In addition, Dr. Meyerhoff singlehandedly raised much needed funds, allowing the agency to increase its professional staff from two to 15, and the board of directors to 25.

A native of Baltimore, Dr. Meyerhoff received his bachelor's degree from the University of Michigan and his medical degree from the University of Pennsylvania. He served his internship and residency in internal medicine at Latter Day Saints Hospital in Salt Lake City, Utah. In 1981, he returned to Baltimore where he completed a rheumatology fellowship at the Johns Hopkins University School of Medicine. An assistant professor of medicine at Hopkins, he is a fellow of the Maryland Chapter of the Arthritis Foundation; a fellow of the American College of Physicians; and a diplomate of the American Board of Internal Medicine. In addition to his work with Parents Anonymous, Dr. Meyerhoff



has served in a variety of positions for the Medical and Chirurgical Faculty of Maryland, the Maryland Chapter of the Arthritis Foundation, the Maryland Society for the Rheumatic Diseases, and the Maryland Lupus Foundation. He is a reviewer for four medical journals and has published extensively in the field.



Roland T. Smoot, M.D., who resides with his wife Minnie in the Baltimore area, received the Maryland Society of Internal Medicine's (MSIM) 1991 Internist of the Year Award in November 1991. MSIM, which locally represents more than 650 internists, was founded in 1956 to promote the optimal delivery of cost-effective, high-quality medical care.



Dr. Smoot received his medical degree from the Howard University School of Medicine. He served his internship and his residency at K.B. Reynolds Memorial Hospital in North Carolina and the Veterans Administration Hospital in Alabama, respectively. Certified by the American Board of Internal Medicine in 1963, Dr. Smoot became a fellow of the American College of Chest Physicians in 1965, and a fellow of the American College of Physicians in 1970.

Currently dean of Student Affairs at the Johns Hopkins University School of Medicine, Dr. Smoot is also an assistant professor of medicine at that institution. Dr. Smoot is presently on the hospital medical staff at Johns Hopkins Hospital, Liberty Medical Center, and St. Agnes Hospital.

An active Med Chi member and member of the Baltimore City Medical Society (BCMS), Dr. Smoot has served as a member of Med Chi's executive committee, the BCMS board of directors, and, ultimately, became president of both organizations. Dr. Smoot also has served as president of the Maryland Thoracic Society and the Baltimore City Medical Society Foundation. He is currently a delegate to the American Medical Association and a member of the board of directors of its American Political Action Committee. In addition, Dr. Smoot has served on a number of community and civic associations including the boards of directors of the Maryland Blue Shield, Inc., the Health and Welfare Council of the State of Maryland, the Maryland Consortium for High Blood Pressure Control, and the Governor's Task Force to Study Arthritis. He is a charter member of the Lois Thomas Minority Leadership and Scholarship Guild at the University of Maryland at Baltimore.

Dr. Smoot has also been the recipient of the A.H. Robins Award for Community Service presented annually by Med Chi, the Equal Opportunity Award given by the Baltimore Urban League, Inc., and the 1989 Martin Luther King, Jr. Humanitarian Award given by the Coalition of Minority

Professional Students at the University of Maryland at Baltimore.

The Maryland medical community is very familiar with Dr. Smoot's long-standing commitment to internal medicine and the care of its patients. J. Leonard Lichtenfeld, M.D., president of MSIM notes, "As a respected member of our community, Dr. Smoot represents the best of internal medicine."



Wayne C. Spiggle, M.D. received the Maryland Society of Internal Medicine's (MSIM) 1991 Special Recognition Award in November 1991.

Dr. Spiggle received his degree in medicine from the West Virginia University and the Medical College of Virginia. Dr. Spiggle served his internship at the Charleston Memorial Hospital and completed his residency at the West Virginia Medical Center. Dr. Spiggle helped establish the Braddock Medical Group in Cumberland — the first group practice of internal medicine in Maryland.

Dr. Spiggle has been very active both in community and medical affairs in Cumberland, as well as throughout Maryland. He has served as a member of the Cumberland Area Chamber of Commerce, as president of Citizens for Responsible Waste Disposal, as chairperson of the Board of Visitors of the Appalachian Environmental Laboratory, and as a member of the Chancellor's Advisory Committee.

Dr. Spiggle has been affiliated with the Sacred Heart Hospital in Cumberland where he has served as chairperson of the Department of Medicine and as president of the Medical Staff. He is a clinical assistant professor of medicine at the University of Maryland School of Medicine, and a visiting clinician at West Virginia University School of Medicine.

On behalf of the Allegany County Medical Society

(ACMS), Dr. Spiggle assisted in founding ACCESS, a program established 15 years ago to facilitate entry of Medicaid patients into the medical care system. More recently, Dr. Spiggle founded Allegany Health Right, an award-winning program in which ACMS cooperates with the entire community to provide health care to "gray area" patients who do not qualify for government aid but who cannot afford health insurance. The program uses private physician offices and private doctor-patient relationships as a working model.

Dr. Spiggle was also selected as a recipient of the A.H. Robins Award for Community Service presented by Med Chi, and the 1991 Community Service Award from the West Virginia Chapter of Common Cause.

Dr. Spiggle and his wife Betty reside on and manage a small farm in Short Gap, West Virginia. ■



AMA'S PHYSICIAN'S RECOGNITION AWARD PHYSICIAN'S RECOGNITION AW



PHYSICIAN'S RECOGNITION AWARD

During November and December of 1991, the physicians listed below received the American Medical Association's (AMA's) Physician's Recognition Award. Established in 1968, the Award's purpose is to encourage physician participation in continuing medical education and to recognize those physicians who have voluntarily completed programs of continuing medical education.

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Bradley, Mark Edmund
Cutler, Leonard Dean
Drakeford, Michael Keith

Hearst, Earl David
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Ionata, Vincent Joseph
Kuehne, Richard F.
Llacuna, Dante Saldares
Mannan, Mohammed Abdul

Ramos, Emilio
Schwalm, Karl Edward
Serpick, Arthur Allen
Warren, William Addison
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COMING OUT OF THE DARK

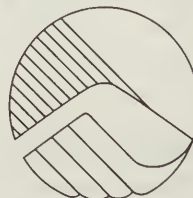
Med Chi's Physician Rehabilitation Committee deals with the substance abuse and mental health problems of Maryland physicians, with a confidential and nondisciplinary focus...Addiction, Marital /Family Conflicts, Psychiatric Illness, Organic Impairment, Physical Handicap...If these problems exist, we can help find the solution. Call us.

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HELPING IS OUR BUSINESS...All donations to the Physician Rehabilitation Committee are used for the delivery of services to Maryland physicians in need of help. If you wish to help further the work of the Committee through a tax deductible donation send your check to: The Medical and Chirurgical Faculty Charitable/Educational Foundation, 1204 Maryland Avenue, Baltimore, Maryland 21201 Please note on your donation: "Physician Rehab"

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Owings Mills—Worthington Park and Foxchase
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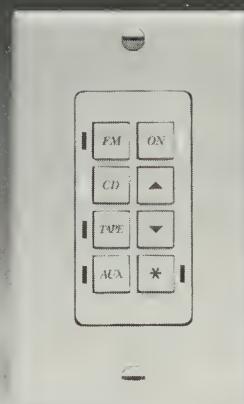
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CME courses: For each course, additional information may be obtained by contacting the Program of Continuing Education, University of Maryland School of Medicine, Room 14-011, BRB, 655 W. Baltimore St., Baltimore, MD 21201 (410-328-3956) or by calling the phone number listed after a specific program. FAX 410-328-3103.

Subspecialty care in general pediatric practice, at the University Club, UMAB campus, Baltimore, MD. 1 Cat 1 AMA/PRA credit. Fee: \$50. Info: Richard Ringel, M.D., 410-328-6666 **Mar. 4 & May 5**

R. Adams Cowley 14th national trauma symposium, at the Hyatt Regency, Baltimore, MD. Info: Kimberly C.A. Unitas, 410-328-2399. **Mar. 6 – 8**

Laparoscopic surgery: The team approach. 14 Cat 1 AMA/PRA credits. Fee: \$2,500. Info: Pat Rahmiow, 410-321-5481. **Mar. 27 – 28**

Current cancer therapy symposium. Info: Sharon Stenhouse, 410-328-3956. **Apr. 3**

Power and medical ethics: The Ipolitas Benedict Bronushas lecture, at the R.A. Cowley Shock Trauma Conference Center Auditorium. Info: 410-448-2770. **Apr. 10**

Infectious diseases in everyday medicine: Second annual symposium, at the Baltimore Convention Center, Baltimore, MD. 12 Cat 1 AMA/PRA credits. Fee: Before April 1, \$175 physicians, \$50 residents and students; After April 1, \$200 physicians; \$75 residents and students. Info: Eunice Katz, 410-328-7560. **Apr. 23 – 24**

18th annual family medicine review course, in Ocean City, MD. 25 Cat 1 AMA/PRA credits. Fee: \$395. Info: Sharon Stenhouse, 410-328-3956. **June 21 – 26**

Continuously throughout the year

Visiting professor program - A 1992 directory of speakers and their topics is available to area hospitals and other health care organizations. NO administrative fees are charged for this service. Info: 410-328-3956.

Departmental rounds and conferences - Weekly, hands-on and lecture presentations hosted by the University's clinical departments. Hour-for-hour Cat 1 AMA/PRA credits available. Brochure available.

Miscellaneous meetings

How to market your medical practice without advertising, at Howard Community College, Columbia, MD. Fee: \$60. Info: Office of Continuing Education, 410-964-4944 or Sheryl Kurland, 410-750-6990. **Feb. 8**

Aging: The quality of life, sponsored by the Christopher Columbus Medical Sciences Committee of the National Institutes of Health, at the Omni Sheraton Hotel, Washington, DC. 21.5 Cat 1 AMA/PRA credits. Fee: \$200; \$250 on site. Info: Suzanne Kuntz, 202-639-4524. **Feb. 10 – 12**

Meeting of the Mid-Atlantic Regional Chapter of the American College of Sports Medicine, at Western Maryland College, Westminster, MD. Info: Dr. Samuel Case, 301-857-2570. **Feb. 21 – 22**

Computers in the medical office, sponsored by the Computers in Medicine Committee, at the Med Chi Faculty building. Fee: \$20. Info: Bruno Mattiello, 410-539-0872 or 1-800-492-1056. **Mar. 7**

Perspectives in orthopaedics and sports medicine, sponsored by the Maryland Academy of Family Physicians, at Wisp Resort, Deep Creek Lake, McHenry, MD. 5 Cat 1 AMA/PRA credits; 5 AAFP prescribed hours. Fee: \$55 MAFP members; \$80 nonmembers; \$35 paramedicals; free for residents, medical students, and MAFP retired and life members. Info: John B. Umhau, Jr., M.D., 410-747-1980. **Mar. 7**

32nd annual scientific session and annual meeting of the Maryland Thoracic Society, at the Baltimore Marriott-Inner Harbor Hotel, Baltimore, MD. 14 Cat 1 AMA/PRA credits. Info: Valerie D. Craig, 410-560-2120. **Mar. 7 – 8**

CME PROGRAMS CME PROGRAMS CME PROGRAMS CME PROGRAMS

The sixth annual review and update course in critical care medicine , sponsored by the Center for Bio-Medical Communication, Inc., at the Hyatt Regency-Capitol Hill, Washington, DC. 35 Cat 1 AMA/PRA credits. Info: Svetlana Lisanti, 201-385-8080.	Apr. 22 – 26
Mini-invasion and megatreatments: Med Chi's 194th annual meeting , at the Omni Inner Harbor Hotel, Baltimore, MD. Info: Betsy Newman, 410-539-0872 or 1-800-492-1056.	Apr. 30 – May 2
The annual meeting of the Virginia Society of Otolaryngology—Head and Neck Surgery , at the Boar's Head Inn, Charlottesville, VA. Info: Donna Scott, 804-353-2721.	May 1 – 2
Trauma is no accident: 92/societal violence—A national epidemic , sponsored by the American Trauma Society, at the McLean Hilton, McLean, VA. Info: 800-556-7890.	May 6 – 8
Rural health: Caring for the country , sponsored by the National Rural Health Association, at the Hyatt Regency Crystal City Hotel, Washington, DC. Info: Robert Quick, 816-756-3140.	May 6 – 9
Clinical auscultation of the heart , sponsored by the American College of Cardiology, at the Georgetown University Medical Center, Washington, DC. 18 Cat 1 AMA/PRA credits. Info: Registration secretary, 800-257-4739.	May 13 – 15
44th annual meeting and scientific session of the Maryland Academy of Family Physicians , at the Sheraton Ocean City Resort and Conference Center, Ocean City, MD. 30.75 Cat 1 AMA/PRA credits; 30.75 AAFP prescribed hours. Fee: \$195 MAFP members; \$225 nonmembers; \$110 paramedicals; free for residents, medical students, and MAFP retired and life members. Info: Francis C. Bruno, M.D., 410-747-1980.	May 13 – 17
Virginia Society of Ophthalmology annual meeting , at the Marriott, Richmond, VA. Info: Donna Scott, 804-353-2721.	May 15 – 16
Revitalization for emergency professionals and spouses , sponsored by the Maryland Chapter, American College of Emergency Physicians, at the Morrison House Hotel, Alexandria, VA. Fee: \$175 physicians; \$25 spouses with physician. Info: 410-727-2237.	May 16
Interactive healthcare '92 conference and exposition , sponsored by Stewart Publishing, Inc. and Interactive Health Care Consortium. Info: 703-354-8155.	June 18 – 21

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9901 Medical Center Drive, Rockville, MD. Info: 301-279-6115.

Overview of the new angiography suite at SGAH.	Feb. 6
ACE inhibition: Hypertension in the mature adult and treatment options in the 90s.	Feb. 13
Cardiac transplantation: Current state of the art.	Feb. 20
Thrombolytic therapy: Current practices, future directions.	Feb. 27
Sleep disorders.	Mar. 5
Nw aspects of allergic rhinitis.	Mar. 12
Advances and controversies in breast reconstruction.	Mar. 19
Pediatric surgery.	Mar. 26
Advances in management of testicular tumors.	Apr. 2
Risk management.	Apr. 9
Psychosocial aspects of caring for the cancer patient.	Apr. 23
Overview of the new angiography suite at SGAH.	Apr. 30

The Johns Hopkins Medical Institutions

All courses at the Turner Auditorium unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Education, 720 Rutland Ave., Baltimore, MD 21205 (410-955-2959).

- 33rd annual postgraduate institute for pathologists in clinical cytopathology** for board certified (or qualified) pathologists as a subspecialty residency. 140 Cat 1 AMA/PRA credits for two courses, both of which must be taken. Preregistration must be completed by March 15, 1992. Feb. – Apr.
- Home study, course A.** Personal reading and microscopic study in preparation for Course B. Feb. – Apr.
In-residence, course B. Concentrated lecture series with intensive laboratory studies. Apr. 6 – 17
- PET and SPECT imaging of living brain chemistry in health and disease.** 19 Cat 1 AMA/PRA credits. Fee: \$495 physicians; \$395 residents. Info: Julia W. Buchanan, 410-955-8582. Mar. 11 – 13
- Perspectives on clinical nutrition: Seminar for nutrition practitioners.** Cat 1 AMA/PRA credits available. Fee: \$240 physicians; \$180 allied health professionals. Mar. 27 – 28
- 4th Baltimore perinatal colloquium.** 23 Cat 1 AMA/PRA credits; ACOG cognates available. Fee: Apr. 1 – 4
 \$450 physicians; \$250 residents.
- Do not resuscitate and beyond: Life and death decision making.** Cat 1 AMA/PRA credits available. Fee: \$75. Apr. 13
- Basic concepts in dysphagia diagnosis and management.** Cat 1 AMA/PRA credits available. Apr. 22
 Fee: \$125 physicians; \$95 residents and allied health professionals.
- 4th multidisciplinary symposium on dysphagia.** Cat 1 AMA/PRA credits available. Fee: \$400 Apr. 23 – 24
 physicians; \$225 residents and allied health professionals.
- Pediatric allergy and immunology for the practitioner.** Cat 1 AMA/PRA credit available. May 7 – 8
- The Philip A. Tumulty topics in clinical medicine 1992.** 38 Cat 1 AMA/PRA credits. Fee: \$650 May 11 – 15
 physicians; \$400 residents and allied health professionals.
- The 5th summer institute in environmental health studies.** Info: Dr. Jacqueline Corn or Catherine Walsh, 410-955-2609. May 18 – 29

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- Visiting preceptorship in pediatric critical care medicine.** Ongoing 5-day preceptorship by appointment. 40 Cat 1 AMA/PRA credits. Fee: \$600.
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- Neuro-ophthalmology conference.** Held twice per month. Info: 410-955-5700.
- Cornea conference.** Held monthly. Info: 410-955-5700.
- The department of radiology and radiological sciences** offers several courses in abdominal and obstetrical ultrasound. Info: P. Williams 410-955-3169.
- Visiting physicians.** Offered throughout the year for experience in the lab and participation in read-in sessions; by appointment only. 40 Cat 1 AMA/PRA credits. Fee: \$500.
- Johns Hopkins medical grand rounds.** Accredited audiovisual continuing education series of case discussions for clinicians; 30 topics per year in five bimonthly programs. Individual and group subscriptions. 40 Cat 1 AMA/PRA credits. Info: 410-955-3988.
- Microsurgery training at the Johns Hopkins Hospital.** One-week program offered continuously throughout the year. 40 Cat 1 AMA/PRA credits. Info: P. Williams 410-955-3169. ■

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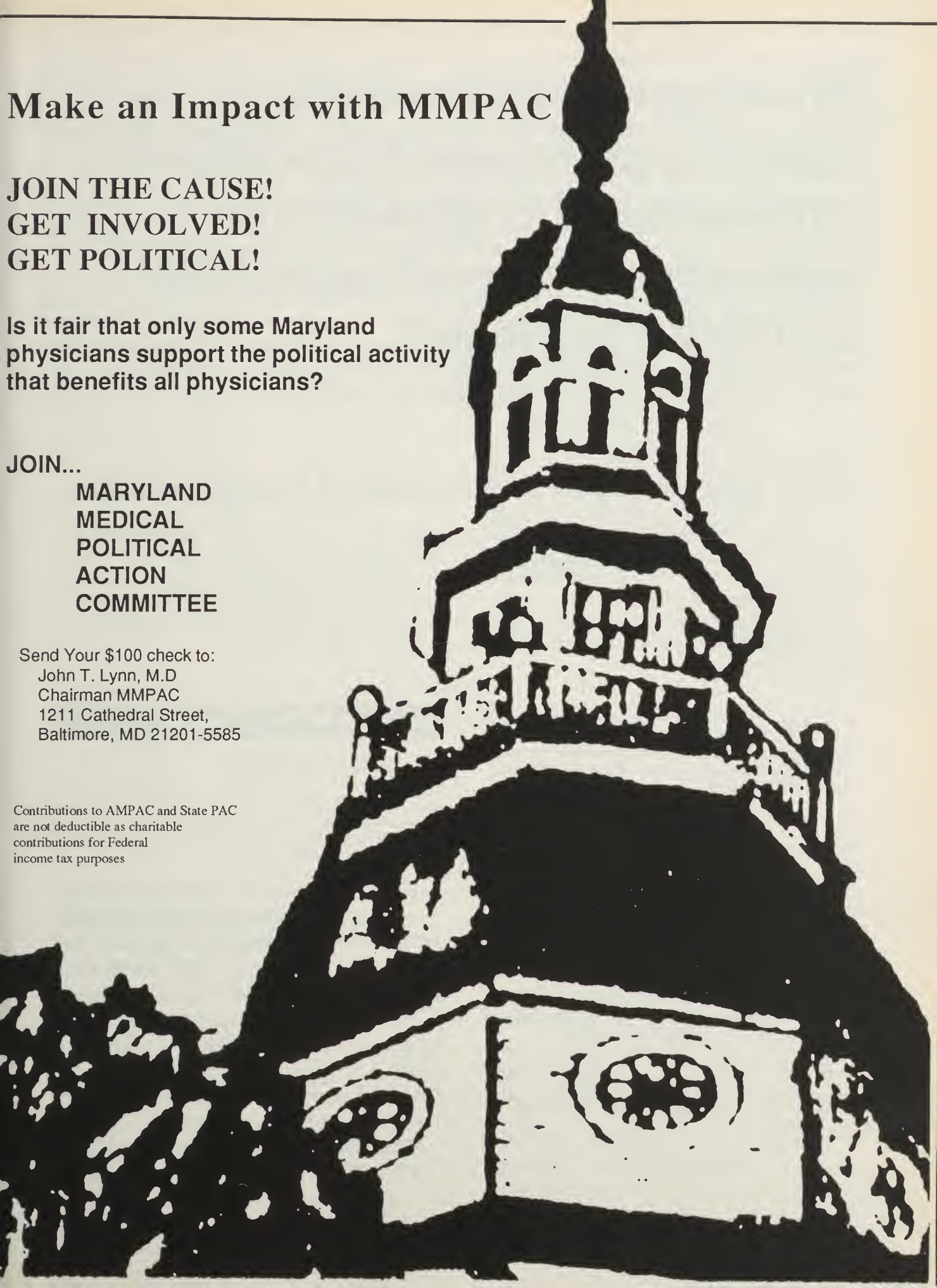
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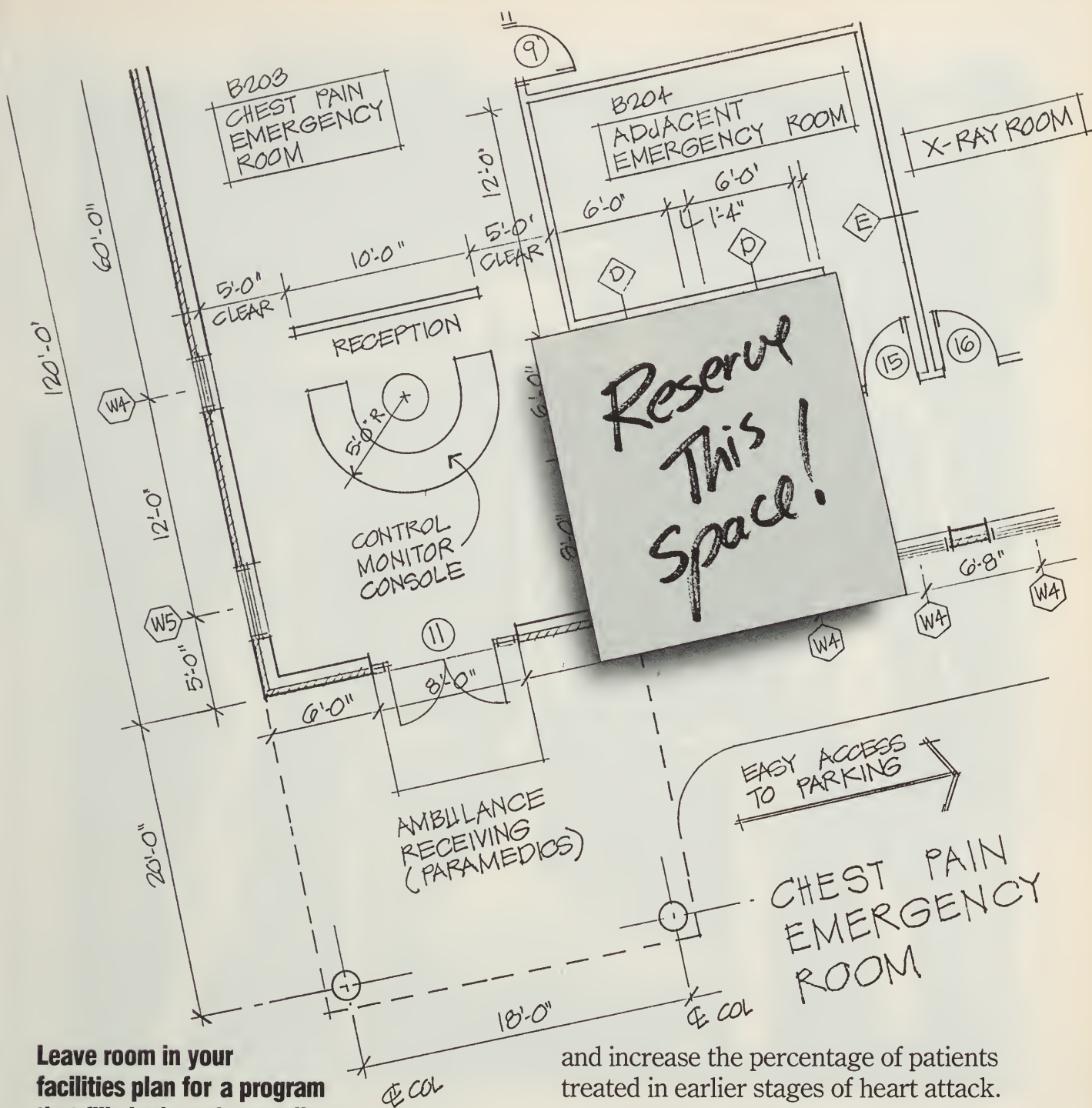
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3. *Gastroesophageal reflux disease (GERD)*—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

Contraindication: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H₂-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H₂-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix[®] may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method. PV 2093 AMP [101591]

Additional information available to the profession on request.



INFORMATION FOR AUTHORS INFO

Manuscripts may be sent to Editor, *MMJ*, 1211 Cathedral St., Baltimore, MD 21201-5585. Articles are accepted for publication on the condition that they are contributed solely to this journal. Transmittal letters should designate one author as correspondent and include his/her address and telephone number. Manuscripts are reviewed by editorial board members and guest reviewers.

Specifications

Manuscripts must be original typed copy, double-spaced throughout (including text, case reports, legends, tables, and references), with pages numbered consecutively. Along with manuscripts, please send an IBM-compatible floppy disk, with the document entered in a WordPerfect or ASCII format.

Include full name of author(s) with highest degrees and academic or professional titles.

Tables with brief descriptive titles are to be typed on separate sheets of paper and numbered. The Editor reserves the right to edit tables. Statistics must be consistent in both tables and text.

An introductory synopsis of approximately twenty-five to fifty words is required.

References are limited to those citations noted in the text and are to be typed double-spaced and numbered consecutively as they appear in the text. The number of references generally is limited to twenty in major contributions and fewer in shorter articles. Personal communications and unpublished data should not be included.

Photographic material must be submitted as high-contrast glossy prints. Drawings and graphs must be of professional quality. Recognizable photos of patients are to be masked and should carry with them written permission for publication.

For more extensive information about preparing medical articles for publication, see *Uniform Requirements for Manuscripts Submitted to Biomedical Journals* compiled by the International Committee on Medical Journal Editors (available through the *Annals of Internal Medicine*).

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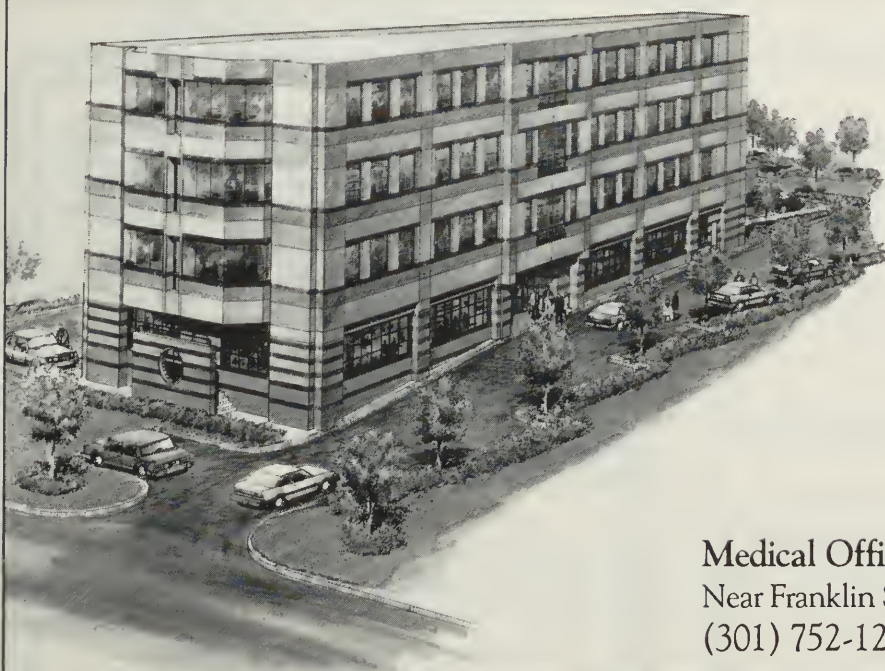
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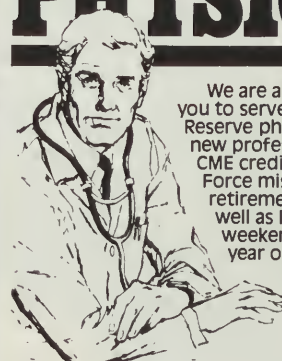
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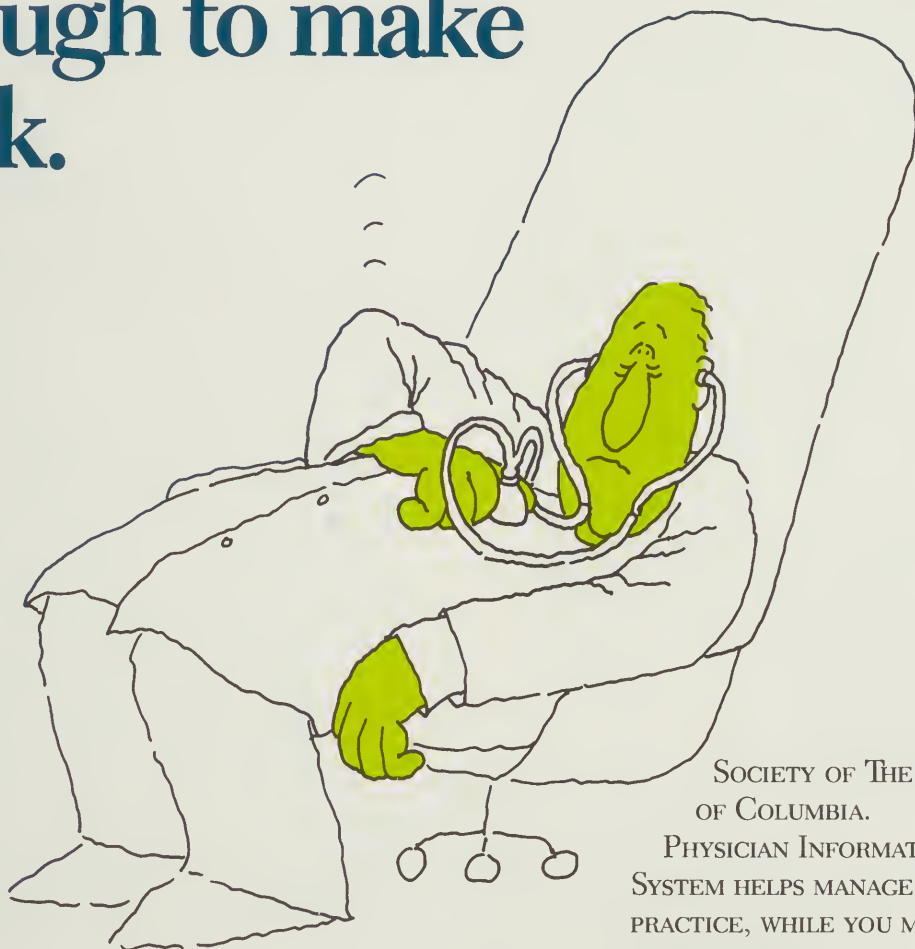


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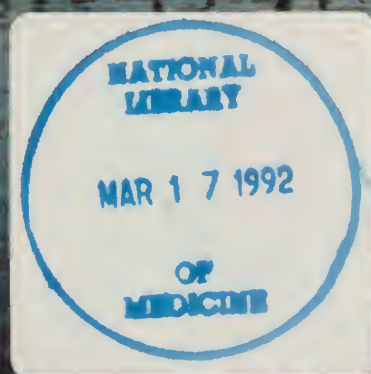
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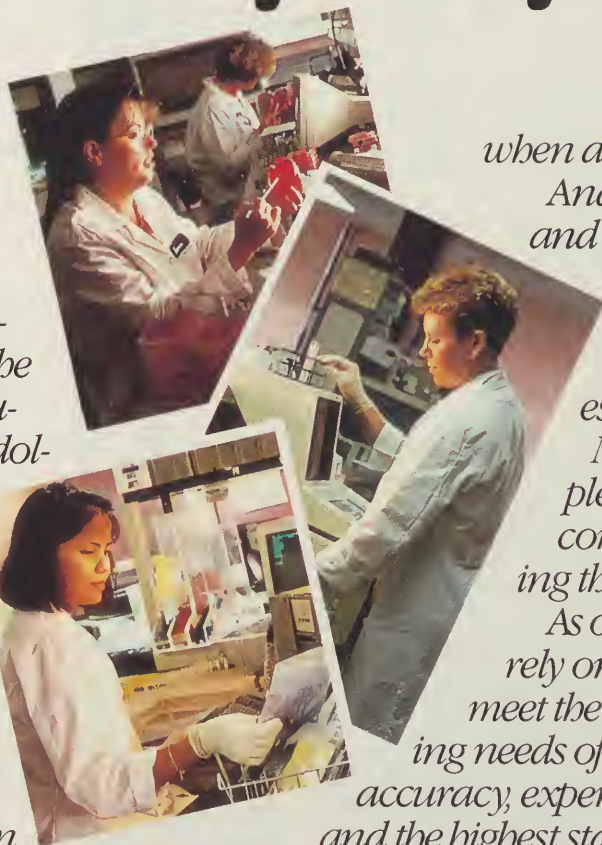
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VOLUME 41 NO 3

^{99m}Tc dimercaptosuccinic acid scan in evaluating patients with urinary tract infection215

Fred Heldrich, M.D.

In clinical practice, determining which patients with urinary tract infection have upper tract involvement is difficult yet important for proper management. This report indicates that the ^{99m}Tc dimercaptosuccinic acid (DMSA) scan is a useful test in making this determination.

Complications of operative and endoscopic gastrostomies219

Jeanette Linder, M.D. and E. George Elias, M.D., Ph.D.

In a retrospective study of fifty cases of gastrostomy insertion performed operatively (OG) or using a percutaneous endoscopic approach (PEG), complication rates were 74 percent (nineteen adults) and 76 percent (seventeen children) in the OG group, and 86 percent (fourteen adults) in the PEG group. While most complications were minor, major ones were usually related to the underlying disease and the general condition of the patient.

Strategies to reduce the high cost of patient noncompliance223

Diane L. McNally, B.S.Pharm and Debra Wertheimer, M.D.

The documented low rate of compliance can result from ineffective communication by the pharmaceutical and medical profession, and poor comprehension of prescription instructions by the public. Presented are several examples of how pharmacists can assist physicians in improving and monitoring their patients' compliance behavior. Strategies to enhance communication through the written prescription are offered.

Community hospital implementation of intraaortic balloon pump therapy for complicated myocardial infarction227

Daniel I. Woronow, M.D., F.A.C.C.

The intraaortic balloon pump may be employed in the community hospital setting to stabilize complicated acute myocardial infarction, even in the presence of thrombolytic therapy.

Hypertriglyceridemia: Severe Type V hyperlipidemia in a young woman231

Rudolf Titanji, M.D. and Aldo Paz-Guevara, M.D.

We present a patient with the typical clinical and biochemical features of severe Type V hyperlipidemia associated with alcohol consumption and estrogen use. Prompt medical intervention resulted in normalization of her lipid profile. We review the lipoprotein composition, the role of lipoproteins in lipid transport with special emphasis on triglycerides, and the clinical features, pathogenesis, and management of Type V hyperlipidemia.

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Editorial Calendar

Upcoming issues of the Maryland Medical Journal will include a focus on physician rehabilitation; a biographical sketch of Jose M. Yosucio, M.D., Med Chi's president-elect, including his plans for the 1992-1993 year; highlights of the career of Richard S. Ross, M.D., dean emeritus of the Johns Hopkins University School of Medicine; the introduction of a new column—Clinicopathology Conferences at Johns Hopkins; and a tribute to John Dennis, M.D., dean emeritus, University of Maryland Medical School.

The MMJ editorial board urges authors to submit original research, case studies, and review articles. We also welcome commentaries and letters to the editor.

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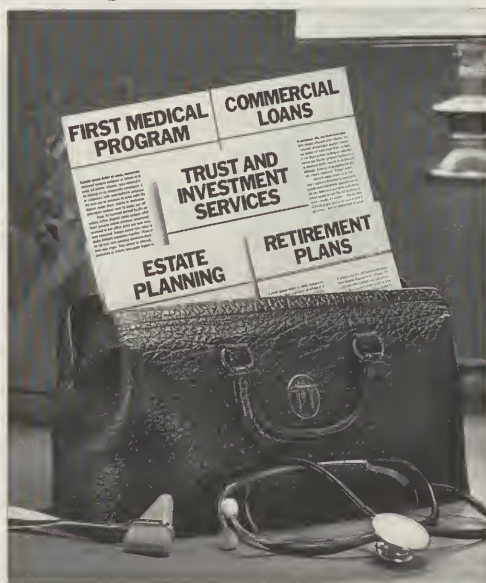
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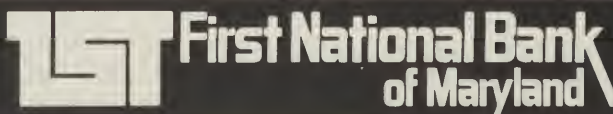


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Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°; 2°; 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecostasia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

4/11/91 • P91CA6277V

Address medical inquiries to:
G.D. Searle & Co.
Medical & Scientific
Information Department
4901 Searle Parkway
Skokie, IL 60077

SEARLE

G.D. Searle & Co.
Box 5110, Chicago, IL 60680

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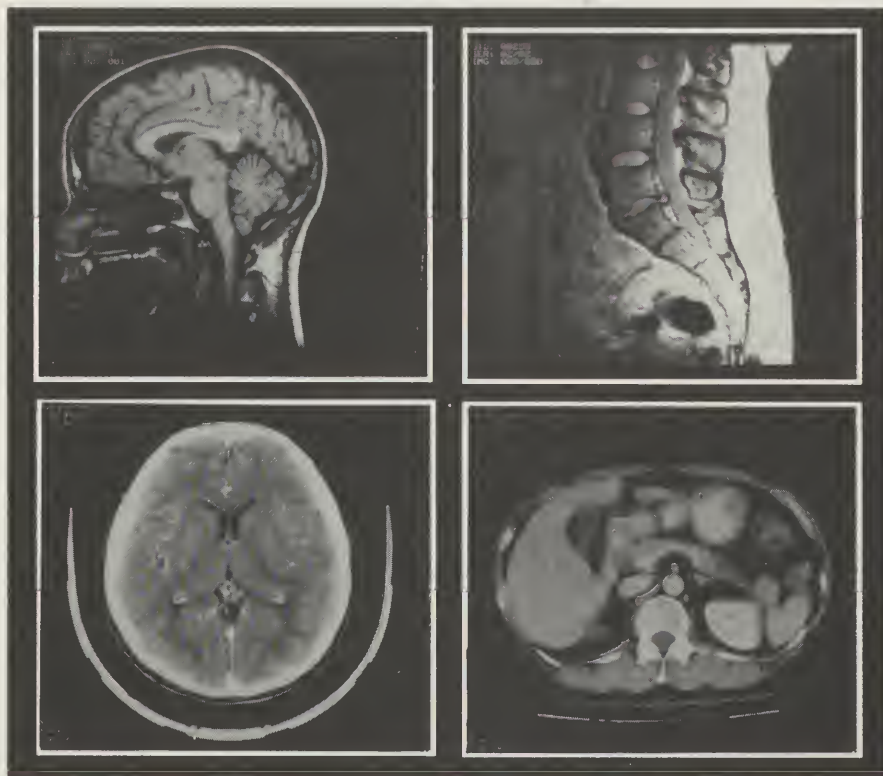
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Quality Service to Our Physicians and Patients!

Annual Meeting

mini-invasion & MEGATREATMENTS

"Mini-invasion and Megatreatments,"
at the

Omni Inner Harbor Hotel
101 West Fayette Street

Baltimore, Maryland

Thursday – Saturday

April 30, May 1 – 2, 1992

This year's meeting focuses on two
exciting new medical technologies:

mini-invasion – the use of "scopes" in
surgical and non-surgical
diagnosis and treatment;
and...

megatreatments – massive treatments
administered to reverse
negative pathology.



Medical and Chirurgical Faculty of Maryland's 194th Annual Meeting "Mini-invasion and Megatreatments,"
at the Omni Inner Harbor Hotel, Thursday – Saturday April 30, May 1 – 2 1992

MEETING REGISTRATION AND SOCIAL EVENT RESERVATIONS

Meeting Registration

Med Chi Members

☐ No Charge

Non-members

☐ Preregistered nonmembers –
\$25.00/presentation hour*

\$25.00 x _____ hours = _____

(indicate number of presentation hours)

*includes both CME & non-CME courses

☐ On-site registration fee for nonmembers – \$15.00
(access limited to exhibit hall only)

total \$25/presentation \$25 x _____ presentation

\$40/mini-symposium \$40 x _____ mini-symposiums

\$ _____

\$ _____

Event Reservations

Event

Member cost

Nonmember cost

☐ Prayer Breakfast,

Friday, May 1, 1992, 7:00 a.m.

\$7.00 (price/person)

_____ # tickets

\$10.00 (price/person)

_____ # tickets

\$ _____

☐ Harbor Cruise

(Reservations required, space is limited)

Thursday, April 30, 1992 6:00 p.m. – 9:30 p.m.

(limit 2 tickets)

No Charge

_____ # tickets

\$35.00 (price/person)

_____ # tickets

\$ _____

☐ Baseball (Reservations required, space is limited)

Baltimore Orioles vs Seattle Mariners

Friday, May 1, 1992 7:35 p.m.

(limit 4 tickets)

No Charge

_____ # tickets

\$10.00 (price/person)

_____ # tickets

\$ _____

☐ Presidential Banquet

Saturday, May 2, 1992, 7:00 p.m.

\$65.00 (price/person)

_____ # tickets

\$75.00 (price/person)

_____ # tickets

\$ _____

TOTAL \$ _____

Form of Payment:

☐ Check payable to Med Chi

☐ Visa

☐ Mastercard

Card #: _____

Signature: _____ Expiration date: _____

Please print clearly:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ County Society: _____

To avoid on-site registration fees, please return your registration form by **April 24, 1992.**

Mail to: Med Chi Convention Department

1211 Cathedral Street, Baltimore, MD 21201-5585

If using your credit card, you may FAX your registration to 410-547-0915 or phone in your registration to Lori Robinson or Vivian Smith at 1-800-492-1056 or 1-410-539-0872.

For questions about the Omni Inner Harbor Hotel or other events at the annual meeting contact Betsy Newman, Public Relations Director, at 1-800-492-1056 or 1-410-539-0872.

Support Our Exhibitors

Exhibits are an integral part of Med Chi's annual meeting and are a valuable adjunct to the scientific program.

By visiting the exhibits before and after your scientific program, you will help ensure that Med Chi continues to receive valuable income that allows us to offer you annual and semiannual meetings.

Med Chi urges you to express your appreciation to exhibitors by visiting their booths and discussing your mutual involvement in patient care.

Exhibits will be open:

Thursday: 12:00 noon to 5:30 p.m.

Friday: 9:00 a.m. to 5:30 p.m.

Saturday: 9:00 a.m. to 12:00 noon

Exhibitor sweepstakes drawings will occur in the exhibit area on:

Thursday: 2:45 p.m.

Friday: 10:45 a.m.

Saturday: 10:45 a.m.

You must be present to win

Continuing Medical Education Credits

The Medical and Chirurgical Faculty of Maryland is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

The Medical and Chirurgical Faculty of Maryland designates this continuing medical education activity for 36.5 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association. Physicians attending this year's meeting can earn up to a maximum of 16.5 CME credits.

For questions about continuing medical education credits or any of the scientific sessions call:

Joan Mannion

Director of Continuing Medical Education,
at 1-800-492-1056 or 410-539-0872.

Meeting Overview*

Thursday, April 30, 1992

8:00 a.m. – 5:00 p.m. – Registration

8:30 a.m. – Council Meeting

9:30 a.m. – House of Delegates Meeting/General Membership Meeting featuring:

Special Guest Speaker

Ron Shapiro, Esq.

9:30 a.m. – Spouse Program

11:00 a.m. – 4:00 p.m. – Auxiliary 43rd Annual Meeting

11:30 – Scientific Session

12:00 noon – 12:30 p.m. – Break – *Visit the Exhibits* –

12:30 p.m. – 1:30 p.m. – Lunch on your own

1:30 p.m. – 2:30 p.m. – Plenary Session

"Health Care Reform"

AMA Trustee Thomas R. Reardon, M.D.

2:30 p.m. – 3:00 p.m. – Break – *Visit the Exhibits* – Exhibitor Sweepstakes Drawing

3:00 p.m. – 6:00 p.m. – Scientific Sessions

4:15 p.m. – Workshop

"Avoiding Excess Retirement and Estate Taxes: Strategies for the 90s"

Med Chi Agency

6:00 p.m. – 9:30 p.m. – Harbor Cruise aboard the *Lady Baltimore* (Reservations required – space is limited)

Friday, May 1, 1992

7:00 a.m. – Prayer Breakfast

8:00 a.m. – 5:00 p.m. – Registration

8:30 a.m. – 4:00 p.m. – Auxiliary 43rd Annual Meeting

8:30 a.m. – 6:00 p.m. – Scientific Sessions

8:30 a.m. – Workshop

"Accreditation for Continuing Medical Education"

10:30 a.m. – Break – *Visit the Exhibits* –

Exhibitor Sweepstakes Drawing

12:00 noon – Auxiliary Meeting and Auction

12:30 p.m. – 1:30 p.m. – Lunch on your own

1:30 p.m. – Mini-Symposium

"Physician Office Labs: Master or Slave?"

4:00 p.m. – Workshop

"Computers in the Medical Office"

7:35 p.m. – Baltimore Orioles vs. Seattle Mariners at the new Oriole Park at Camden Yards (Reservations required – space is limited)

Saturday, May 2, 1992

8:00 a.m. – 12:00 noon – Registration

8:30 a.m. – Mini-Symposium

"Ethics of Dying"

8:30 a.m. – 1:00 p.m. – Scientific Sessions

10:30 a.m. – 11:00 a.m. – Break – *Visit the Exhibits* – Exhibitor Sweepstakes Drawing

11:00 a.m. – Spouse Program

12:30 p.m. – 1:30 p.m. – Lunch on your own

2:00 p.m. – House of Delegates Meeting

3:00 p.m. – Council Meeting

7:00 p.m. – Presidential Banquet

Honoring Med Chi President J. David Nagel, M.D. (Reservations required – black tie optional)

Medical and Chirurgical Faculty of Maryland's 194th Meeting Mini-invasion and Megatreatments

at the Omni Inner Harbor Hotel
101 West Fayette Street, Baltimore, Maryland

Thursday – Saturday, April 30, May 1 – 2, 1992

Preliminary Schedule

THURSDAY, APRIL 30, 1992

8:00 a.m. – 5:00 p.m. – Registration

8:30 a.m. – Council Meeting

9:30 a.m. – House of Delegates Meeting

Special Guest Speaker

Ron Shapiro, Esq.

9:30 a.m. – Spouse Program

"Personal Safety and Self-Defense for the 90s"

presented by Citizens Against Crime

11:00 a.m. – 4:00 p.m. Auxiliary 43rd Annual Meeting

11:30 a.m. – *"Current Guidelines for the Diagnosis and Treatment of Bronchial Asthma"*

Maryland Asthma and Allergy Society

CME Credits: 1

12:00 noon – 12:30 p.m. – Break – Visit the Exhibits

12:30 p.m. – 1:30 p.m. – Lunch on your own

1:30 p.m. – 2:30 p.m. – Plenary Session

"Health Care Reform"

AMA Trustee Thomas R. Reardon, M.D.

2:30 p.m. – 3:00 p.m. – Break – Visit the Exhibits

Exhibitor Sweepstakes Drawing

3:00 p.m. – Scientific Sessions

"Primary Care Follow-up of the Cancer Patient"

Maryland Academy of Family Physicians

CME Credits: 1.5

"Efficacy vs Expense: Maximizing Drug Therapy Outcomes in Your Patient"

Med Chi Committee on Therapeutic Education

CME Credits: 2

"A Fifteen-Year Overview of Focused Remedial Education: A Look at its Present and Future"

Med Chi Committee on Focused Professional Education

CME Credits: 1

4:30 p.m. – Scientific Sessions

Topic To Be Announced

The John Staige Davis Society of Plastic Surgeons of Maryland

CME Credits: TBA

"Endoscopy in Gynecology"

Infertility Associates

CME Credits: TBA

4:15 pm – Workshop

"Avoiding Excess Retirement and Estate Taxes: Strategies for the 90s"

Med Chi Agency

CME Credits: None

6:00 p.m. – 9:30 p.m. – Harbor Cruise aboard the *Lady Baltimore*

featuring dinner buffet & dancing

(Reservations required - space is limited)

FRIDAY, MAY 1, 1992

7:00 a.m. – Prayer Breakfast

"The Physician's Responsibility to Notify the Patient: Duty and Morality"

Med Chi Committee on Medicine and Religion

CME Credits: 1

8:00 a.m. – 5:00 p.m. – Registration

8:30 a.m. – 4:00 p.m. – Auxiliary 43rd Annual Meeting

8:30 a.m. – Scientific Sessions

"Claims Abstracts: Learning From Experience"

Medical Mutual Liability Insurance Society of Maryland

CME Credits: 2

Fee of \$40.00 required for this course. Register at door.

"Therapeutic Gastrointestinal Endoscopy"

Maryland Society of Gastrointestinal Endoscopy

CME Credits: 2

"Innovative Strategies for Risk Management"

American Heart Association – Maryland Chapter

CME Credits: 2

8:30 a.m. – Workshop

"Accreditation for Continuing Medical Education"

Med Chi Continuing Medical Education Review Committee

(invitational workshop for CME directors/staff)

CME Credits: None

10:30 a.m. – 11:00 a.m. – Break – Visit the Exhibits – Exhibitor Sweepstakes Drawing

11:00 a.m. – Scientific Sessions

"Megatrends in Dermatology"

Maryland Dermatological Society, Inc.

CME Credits: 1.5

"How to Help Your Patients Quit Drinking"

Med Chi Committee on Alcoholism and
Chemical Dependency

CME Credits: 1

"Children and Youths as Performing Artists: Protection of Hearing and Vision"

Med Chi Committee on Medicine and the Performing Arts

CME Credits: 1

"The Battered Women Syndrome – The Hidden Trauma"

Maryland Psychiatric Society Women's Committee in co-
operation with the Med Chi Women in Medicine Committee

CME Credits: 2

12:00 noon – Auxiliary Meeting and Auction

12:30 p.m. – 1:30 p.m. – Lunch on your own

1:30 p.m. – Mini-Symposium

"Physician Office Labs: Master or Slave?"

Med Chi Ad Hoc Committee on Laboratory Regulations

CME Credits: 2

4:00 p.m. – Scientific Sessions

"Caring for the HIV-Positive Patient"

Med Chi Committee on AIDS

CME Credits: 2

"Detection and Office Management of Patients with Eating Disorders"

Governor's Task Force on Eating Disorders

CME Credits: 1

"Physicians and the Media"

Med Chi Public Relations Committee

CME Credits: 1

"Substance Abuse: Physician Attitudes, Beliefs and Practices"

Med Chi Committee on Alcoholism and Chemical
Dependency

CME Credits: 1

4:00 p.m. – Workshop

"Computers in the Medical Office"

Med Chi Committee on Computers in Medicine

CME Credits: None

5:00 p.m. – Scientific Sessions

"Micronutrients and Megavitamins: What's New, What's True"

Med Chi Committee on Mental Health

CME Credits: 1

7:35 p.m. – Baltimore Orioles vs Seattle Mariners –

at the new Oriole Park at Camden Yards

(Reservations required – space is limited)

SATURDAY, MAY 2, 1992

8:00 a.m. – 12:00 noon – Registration

8:30 a.m. – Mini-Symposium

"Ethics of Dying"

Med Chi Committee on Professional Ethics

CME Credits: 2

8:30 a.m. – Scientific Sessions

"Provocative Radiologic Techniques: Discography, Facet Blocks, and Nerve Blocks"

Maryland Society of Physical Medicine and Rehabilitation

CME Credits: 2

"Adjuvant Therapy of Breast Cancer: Prognosis and Perspectives"

Maryland Medical Breast Society

CME Credits: 2

10:30 a.m. – 11:00 a.m. – Break - Visit the Exhibits –

Exhibitor Sweepstakes Drawing

11:00 a.m. – Scientific Sessions

"Stereotactic Core Biopsy of Breast Lesions – An Alternative to Surgical Excision"

Diagnostic Breast Center of Cross Keys

CME Credits: 1

"Medical Management in Home Care"

Med Chi Long-Term Care and Geriatrics Committee in
cooperation with the American Medical Association

CME Credits: 2

11:00 a.m. – Spouse Program

"Stress in the Physician's Family"

12:30 p.m. – 1:30 p.m. – Lunch on your own

2:00 p.m. – House of Delegates Meeting

3:00 p.m. – Council Meeting

7:00 p.m. – Presidential Banquet

Honoring Med Chi President J. David Nagei, M.D.

(Reservations required – black tie optional)

*Note: dates, times, session speakers, and topics in this program are subject to change.

Fun Things To Do



Social Events

Med Chi physicians are invited to participate in a wide variety of social events at this year's meeting. Because space is limited, Med Chi is requiring advance registration for all events. To reserve your space, complete the attached registration form or call Vivian Smith at 410-539-0872 or 1-800-492-1056.

Thursday, April 30

6:00 p.m. – 9:30 p.m. Harbor Cruise aboard the *Lady Baltimore*

Dinner buffet and dancing
(Reservations required – space is limited)

Friday, May 1

7:35 p.m. – Baltimore Orioles vs Seattle Mariners
at the new Oriole Park at Camden Yards
(Reservations required – space is limited)

Saturday, May 2

7:00 p.m. Presidential Banquet
Honoring Med Chi President J. David Nagel, M.D.
(Reservations required – black tie optional)

For Your Family...Activities in Baltimore

While you attend scientific sessions, your family can visit a wide variety of Baltimore attractions and shops including

Baltimore Zoo	396-7102/366-5466
The Baltimore Museum of Art	396-7100
Edgar Allen Poe House	396-7932
Fort McHenry National Monument and Historic Shrine	962-4299
Harborplace and The Gallery	332-1491
Lexington Market	685-6169
Maryland Science Center	685-5225
National Aquarium in Baltimore	576-3810
Shot Tower	837-5424
U.S. Frigate Constellation	537-1979
Walters Art Gallery	547-9000
World Trade Center – Top of the World	837-4515

A more complete listing of family activities and dining opportunities will be available at the annual meeting.

Hotel Reservations

The Omni Inner Harbor Hotel is the largest hotel in Maryland and offers luxurious guest accommodations.

Med Chi has reserved a limited number of rooms at a special group rate of \$105.00 plus tax for single/double rooms with a \$16 plus tax charge for each additional person. Children under age 15 stay free.

To receive this special discounted room rate, you must make your hotel reservations by **March 29, 1992**.

To make a reservation call: 1-800-THE-OMNI (1-800-843-6664)

Guest check-in time is 3:00 p.m. and check-out time is 12:00 noon.

Telephone Messages

During the meeting, messages may be relayed to registrants by calling 1-410-752-1100.

Directions to the Omni Inner Harbor Hotel

101 West Fayette Street

Baltimore, Maryland 752-1100

- 95 South – Through Fort McHenry Tunnel to 395 North (Exit 53). Follow 395 North 1/2 mile to Pratt Street, turn right. Go two blocks and turn left onto Charles Street. Go four blocks and turn left onto Fayette Street. The Omni is one block ahead on the left.
- 83 South – Take (Exit 23) off 695 to get on I-83 South. Go to end of expressway. Turn right at first traffic light, which is Fayette Street. The Omni is seven blocks on the left.
- 95 North – Take exit 53, which is 395 North. Follow 395 1/2 mile to Pratt Street, turn right. Go two blocks to Charles Street and turn left. Go four blocks to Fayette Street and turn left. The Omni is one block ahead on the left.
- BWI Parkway – North (295)- 295 North becomes Russell Street near Baltimore. From Russell Street, turn right onto Pratt Street. Go five blocks and turn left onto Charles Street. Go four blocks and turn left onto Fayette Street. The Omni is one block ahead on the left.
- 70 East – Follow 70 East to 40 East (Edmondson Avenue). Edmondson Avenue becomes Mulberry Street. Follow Mulberry to St. Paul Street and make a right. Go three blocks to Fayette Street and turn right. The Omni is two blocks ahead on the left.
- 40 West – 40 West becomes (Pulaski Highway) Orleans Street in Baltimore. Turn left at St. Paul Street. Go four blocks to Fayette Street and turn right. The Omni is two blocks ahead on left.



Hotel Information

Parking

The following parking locations are within walking distance of the Omni Inner Harbor Hotel. For your convenience, parking lot locations and prices are listed below.

Valet Parking at the Omni Inner Harbor Hotel

Rates:

\$9.00 per 24-hour period
unlimited in/out privileges

Self Park

Alright Parking

Located at the Omni Inner Harbor Hotel - Because this garage is not owned by the hotel, parking spaces cannot be reserved or guaranteed.

Hourly Rates or:

\$7.00 - 2 - 10 hours
\$9.00 - 10 - 24 hours

Down Under Parking

Rates :

\$8.25 - For any parking over 3 hours
\$3.25 - Flat rate on Saturday & Sunday

Arrow Parking

Hourly Rates or:

\$6.00 - In by 9:30, out by 7:30 p.m.

1st Maryland Garage

Hourly Rates or:

\$9.00 - Maximum for day
\$4.00 - Flat rate on Saturday & Sunday

Park and Lock

Hourly Rates or:

\$9.00 - 3 - 24 hours
\$4.00 - Flat rate on Saturday & Sunday

Fayette West Lot

Hourly Rates or:

\$9.00 - 3 - 24 hours
\$4.00 - Flat rate on Saturday & Sunday



Executive Director's Newsletter

March 1992

Preliminary Program for
1992 Med Chi Annual Meeting

Preliminary Program for 1992 Med Chi Annual Meeting

Preceding this newsletter is the preliminary program for Med Chi's 1992 annual meeting to be held Thursday-Saturday, April 30, May 1-2, 1992 at the Omni Inner Harbor Hotel. Featured speakers at the meeting include AMA Trustee Thomas Reardon, M.D., who will speak on "Health Care Reform" on Thursday, April 30, 1992.

Scientific sessions for this year's meeting will feature a variety of topics including

- Ethics of Dying
- Laboratory Regulations
- Domestic Violence
- Primary Care of Patients with HIV
- Risk Management

Social events for this year's meeting include

- Harbor cruise aboard the Lady Baltimore on Thursday, April 30
- Baseball game at the new Orioles Park at Camden Yards on Friday, May 1
- Presidential banquet honoring Med Chi President J. David Nagel, M.D. on Saturday, May 2

Physicians interested in attending the scientific sessions or the social events are encouraged to complete the registration form on the preliminary program preceding this newsletter. For more information about the meeting, contact Vivian Smith at 410-539-0872 or 1-800-492-1056.

President's Regional Conference— Southern Maryland

Physicians in southern Maryland should note the date and time for the President's Regional Conference for Southern Maryland:

*Thursday, March 12, 1992, at 5:30 p.m.
at the Solomons Island Holiday Inn.*

The program will feature updates on important Med Chi issues and a presentation on the AMA's Health Access America. The meeting will also feature a 1-hour CME session on "How to Detect and Treat Nicotine Addiction.*"

Physicians wishing to attend this conference should call Lori Robinson in Med Chi's Communications Department at 1-800-492-1056 or 410-539-0872.

School Immunizations and Second-Dose Measles Vaccine

The Maryland Department of Health and Mental Hygiene (DHMH) has proposed regulations to require children who enter kindergarten and sixth grade in September 1992 to have proof of having received two doses of measles vaccine and proof of having received one dose of mumps vaccine, or a blood test showing immunity to both diseases. Other requirements for DTP, OPV, and rubella remain the same.

We expect the revised COMAR 10.06.04 to be effective by late April 1992. It is important that physicians note these changes in order to respond to requests for second-dose measles vaccine (preferably as MMR).

You may call the Epidemiology and Disease Control Program at DHMH (410-225-6679) if you have specific questions.

* The Medical and Chirurgical Faculty of Maryland is accredited by the Accreditation Council of Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

The Medical and Chirurgical Faculty designates this continuing medical education activity for 1 credit hour in Category 1 of the Physician's Recognition Award of the American Medical Association.

Vaccine Information Pamphlet

Health care providers who administer certain vaccines are required by the National Childhood Vaccine Injury Act of 1986 to provide information to the patient/parent utilizing the Vaccine Information Pamphlet (VIP), or health care providers may develop their own information materials that meet the requirements of the Act.

Information to be provided to the patient/parent is found in the VIP. These pamphlets will be issued for DTP, OPV, and MMR. By April 1, 1992, the Immunization Division of DHMH will supply all Maryland health care providers with reproducible copies for bulk printing. (Users of vaccine supplied by the DHMH will receive the VIPs in quantities to match vaccine use, as is now done with the Important Information Statements.) If you have any questions, please call the Epidemiology and Disease Control Program at 410-225-6679.

Workers Compensation Claims— CPT Codes

Physicians should note that the new evaluation and management codes that are described in the current (1992) CPT book, shall not be used for workers compensation claims. Until further notice, please continue to use the codes found in all prior CPT editions for these services. For more information, contact Lourenna E. Fisher at the Workers Compensation Commission at 410-333-4700.

New CPT Evaluation and Management Codes for 1992

In an effort to keep you apprised of the latest developments in CPT evaluation and management codes for 1992, Med Chi is providing answers to commonly asked questions following this newsletter. This list was prepared by the Health Care Financing Administration. Watch the Executive Director's Newsletter for additional questions and answers about CPT codes in the coming months.

OSHA Regulations

Physicians interested in the new U.S. Department of Labor, Occupational Safety and Health Administration (OSHA) regulations for infection control in the health care setting, should see the Epidemiology and Disease Control Program newsletter on page 261 of this MMJ for more information.

Committee Selection Cards 1992-1993

Med Chi members interested in serving on a Med Chi committee during the 1992-1993 committee year, should complete the committee selection card following this newsletter. All members should complete this card to be considered for appointment.

Physician Volunteers for the Board of Physician Quality Assurance Needed

Med Chi is seeking practicing licensed Maryland physicians who are interested in serving as members of the Board of Physician Quality Assurance. Med Chi is responsible for submitting a list to the governor of physicians who meet this requirement. Med Chi is soliciting volunteers from component medical societies and is advertising in the news media for non-member volunteers to serve on the board.

Med Chi membership is not required for appointment to the Board of Physician Quality Assurance

If you are interested in serving on the board, please send your curriculum vitae, no later than March 16, 1992, to

*Executive Director
Med Chi
1211 Cathedral Street
Baltimore, MD 21201-5585*

For more information, contact the Executive Director's office at 410-539-0872 or 1-800-492-1056.

Computers in the Medical Office

Med Chi's Computers in Medicine Committee is sponsoring "Computers in the Medical Office," a three-part seminar on Saturday, March 7, 1992, from 9 a.m. to 2 p.m. in the Med Chi Faculty Building. The seminar is intended for physicians who want to expand their office computer capabilities or for those physicians who do not yet have computer equipment and would like guidance in the selection of hardware and software.

The first part of the seminar will review computerizable office functions and various examples of software that will meet those functions. The second part of the seminar will address the hardware requirements as determined by needed software and practice size. The third part of the seminar will be hands-on demonstrations of computer equipment by all participants. Registration for the seminar is \$20. Physicians interested in attending should contact Bruno Mattiello at 410-539-0872 or 1-800-492-1056.

Dear Doctor Column

Med Chi is seeking physicians interested in contributing to a "Dear Doctor" column to be published as a Med Chi public service in area newspapers. Physicians from every medical specialty are encouraged to participate in this project that will help convey critical medical information to the public. These columns would be in a question-and-answer format and would be approximately 500 words in length. If you are interested in participating in this project, call Med Chi's Public Relations Department at 301-539-0872.

Medicare Computer Problems—Maryland Blue Cross/Blue Shield

It has come to the Faculty's attention that patients have been receiving from Maryland Blue Cross/Blue Shield EOBs (explanation of benefits) that contain incorrect information. The types of errors that are appearing on the EOBs are

1. The name of the physician providing the services is listed incorrectly.
2. The type of injection given to the patient is listed incorrectly.
3. Claims are being incorrectly rejected for covered services.

Since this information has been generated from the insurance carrier and not from the physician's office, physicians should inform their patients that they should call Medicare's beneficiary telephone line to register their complaints.

The beneficiary telephone numbers for Maryland Blue Cross/Blue Shield are 1-800-492-4795 or 561-4160. Physicians are not to use these telephone lines for provider questions or problems.

Erratum

Incorrect dates for events during the 1992 Med Chi annual meeting were published in the February *Maryland Medical Journal* (MMJ). The correct dates and times are as follows:

Thursday, April 30, 1992

Council 8:30 a.m.

House of Delegates 9:30 a.m.

Saturday, May 2, 1992

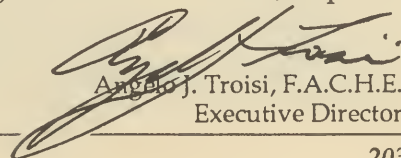
House of Delegates 2:00 p.m.

Council 3:00 p.m.

The correct date for the presidential banquet is *Saturday, May 2, 1992* at 7:00 p.m. For more information about the annual meeting, see the preliminary program preceding this newsletter.

Erratum

Nielsen Andrews co-authored the article "Legislative preview: An overview of legislative issues affecting Maryland medicine in 1992" that was published on page 25 of the January issue of the *MMJ*, along with Gerard E. Evans, Esq.


Angelo J. Troisi, F.A.C.H.E.
Executive Director

New CPT Evaluation and Management Codes for 1992

Questions and Answers

1. What does the term "time" refer to in the codes?

Time in the office or other outpatient services and office consultation categories means the time that the physician typically spends face-to-face with the patient and/or family.

Time for inpatient hospital care, initial and follow-up hospital consultations, and nursing facilities refers to the time the physician spends in the patient's unit and at the bedside.

Time is deliberately not included in the emergency department visit codes because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time.

For a more detailed explanation of "time," see the Evaluation and Management Guidelines in the 1992 CPT book, page 4.

2. Does face-to-face time in a physician's office include the time of the nurse if the nurse obtains history, etc. for the physician?

No. Face-to-face time refers to the time with the physician only. The appropriate code should be selected based on the content of the visit or consultation; time is included to assist the physician in code selection.

3. Can time alone ever be used to select a code?

Yes. When counseling and/or coordination of care dominate (more than 50 percent) the face-to-face physician/patient encounter, time is the key or controlling factor. The code selection is based on the total time of the face-to-face encounter, not just the counseling time. The medical record must be documented in sufficient detail to justify the selection of the specific code.

4. If a physician sees his patient in the emergency room and decides to admit the person to the hospital, should both services (the emergency department visit and the initial hospital visit) be reported?

No. When the patient is admitted to the hospital via another site of service (e.g., hospital emergency department, physician's office, nursing facility), all services provided by the physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission. See page 18 of the 1992 CPT book for more explanation.

5. If a patient is seen in the office at 3:00 p.m. and admitted to the hospital at 1:00 a.m. the next

day, may both the office visit and the initial hospital care be reported?

Yes. Because different dates are involved, both codes may be reported. The CPT states services on the same date must be "rolled up" into the initial hospital care code. The term "same date" does not mean a 24-hour period. See page 18 of the 1992 CPT book for more explanation.

6. Are physicians assigned to the emergency department the only physicians who may use the emergency department services codes?

No. Any physician seeing a patient registered in the emergency department may use these codes.

7. If an office visit is for a true emergency, may the emergency department visit codes be used?

No. The emergency department codes should only be used if the patient is seen in the emergency department. The emergency department is defined as an organized hospital-based facility for the provision of unscheduled or episodic services to patients who present for immediate medical attention.

8. Should non-emergency services performed in the emergency department be reported using emergency department codes?

Yes. The only requirement for using the emergency department codes is that the patient be registered in the emergency department. Normally a lower level emergency department code would be reported for such a non-emergency condition. Office or other outpatient codes should be used if the patient is seen in the emergency room as a convenience to the physician.

9. Referring to number 8 above, will Medicare payment be reduced for the non-emergency service?

No. Starting on January 1, 1992, the site-of-service reduction does not apply to the emergency department evaluation and management codes.

10. May a physician report both a hospital visit and hospital discharge day management service on the same day?

No. The hospital visit descriptors include the phrase "per day" meaning they include all care for a day. Code 99238 (hospital discharge day management services) is used to report services on the final day of the hospital stay. To report both the hospital visit code and the hospital discharge day management services code would be duplicative.

I am interested in serving on the following Med Chi committee(s):

Each year Med Chi requests physicians to serve on its more than 45 committees. These committees are the backbone of our organization and guide the decisions made by Med Chi's House of Delegates, Council and Executive Committee. To assure that Med Chi remains a strong and active organization, it is essential that physicians participate as active members of these committees.

As President for 1992-93, I intend to appoint as many physicians as possible to committees. Please indicate your willingness to serve by checking your preference and special interests on the attached reply card. Every effort will be made to appoint you to the committee of your choice.

Med Chi is your organization. By serving on a Med Chi committee, you can help protect and improve Maryland medicine.

Thank you for your assistance

Jose M. Yosuco MD
President-elect

- | | |
|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Occupational Health |
| <input type="checkbox"/> Alcoholism and Chemical Dependency | <input type="checkbox"/> Peer Review |
| <input type="checkbox"/> Computers in Medicine | <input type="checkbox"/> Peer Review Management |
| <input type="checkbox"/> Continuing Medical Education Review | <input type="checkbox"/> Physician/Patient Relations |
| <input type="checkbox"/> Drugs | <input type="checkbox"/> Physician Rehabilitation |
| <input type="checkbox"/> Emergency Medical Services | <input type="checkbox"/> <i>Physician's Practice Digest</i> Editorial Board |
| <input type="checkbox"/> Finance | <input type="checkbox"/> Professional Ethics |
| <input type="checkbox"/> Focused Professional Education | <input type="checkbox"/> PRO Monitoring |
| <input type="checkbox"/> Hospital Medical Staffs | <input type="checkbox"/> Public Health |
| <input type="checkbox"/> Insurance Fund of Med Chi | <input type="checkbox"/> Immunization and Infectious Diseases Subcommittee |
| <input type="checkbox"/> Legislative | <input type="checkbox"/> Infant, Child & Adolescent Health Subcommittee |
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☐ Other Interests: _____

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Case #19

A 50 year old man experienced shoulder pain and weakness after catching himself with his arm during a fall.

DIAGNOSIS: Rotator cuff tear involving the supraspinatus tendon.

Figure 1 demonstrates a torn and retracted supraspinatus tendon (arrow). The tendon defect (arrowheads) can be accurately quantitated to assist surgical planning. Figure 2 demonstrates a normal supraspinatus tendon inserting laterally on the humerus (H). Acromion (A). Glenoid (G). Supraspinatus muscle (SSM).

The supraspinatus tendon represents the component of the rotator cuff most often found to be torn and/or degenerated. Many supraspinatus tendon tears result from chronic abrasion of the tendon by the acromion and acromioclavicular joint. In addition to documenting complete and partial tears of the rotator cuff, MRI also evaluates the relationship between the acromion and the supraspinatus tendon, providing a means to detect impingement before tears have occurred. MRI also proves useful in assessing labral injuries associated with instability, subacromial and subdeltoid bursal fluid collections, biceps tendon tears, and osseous injuries. As with examination of the knee and other joints, MRI provides a comprehensive evaluation of soft tissue and osseous pathology afflicting the shoulder.

FIGURE 1

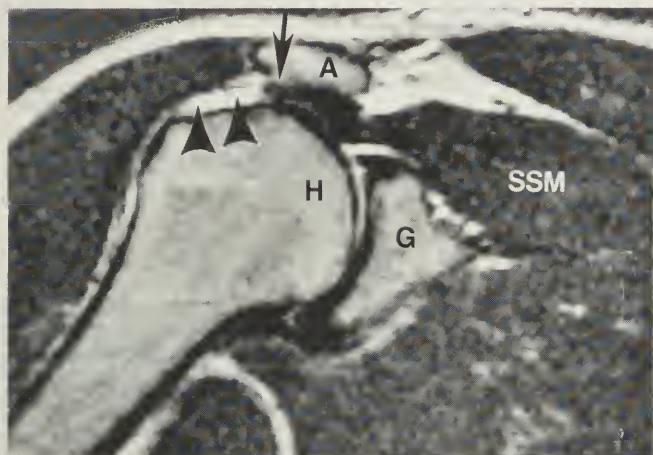
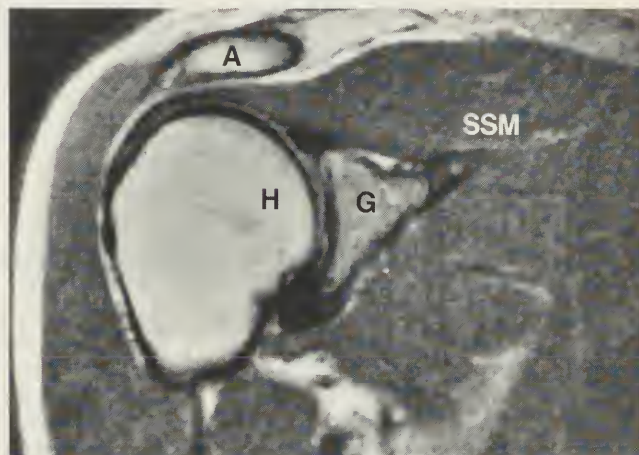


FIGURE 2



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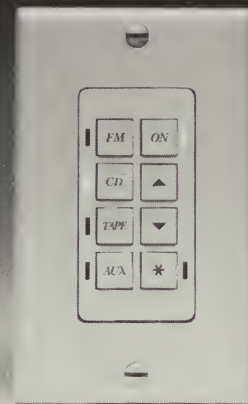
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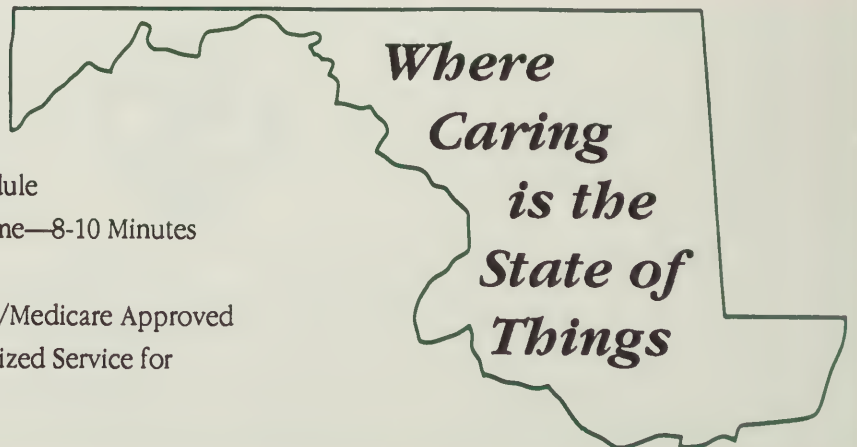
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Our two-part ambulatory treatment program includes: 1) Healing the ulcer itself by isometric compression therapy; 2) Addressing the underlying cause and preventing recurrence through injection sclerotherapy of incompetent perforating veins and refluxing varicose veins.

Rapid closing of ulcer.

The common denominator of most leg ulcers is venous pump failure with edema. Our treatment first removes the edema and heals the ulcer through the application of isometric compression bandaging. This increases venous outflow during ambulation, resulting in improved pump action at the calf muscle.

Healing occurs in three to six weeks for most patients, or longer in more advanced cases. Other advantages of this phase include immediate ambulation, rapid elimination of pain and drainage and high patient acceptance.



D.K., a 69-year-old woman with recurrent ulcer and history of skin graft failures, on initial day of treatment. Edema of ankle and inflammation clearly visible.

Effective long-term healing.

Once the ulcer has healed and other problems such as edema and dermatitis are under control, the second phase of treatment can address prevailing underlying causes. Refluxing venous trunks, tributaries and incompetent perforating veins are

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This selective fibrosis process improves the venous pump, resulting in long-term healing and lowered recurrence of leg ulcers.

Proven treatment program with documented results.

This treatment protocol was developed over 10 years of clinical experience, with favorable results on approximately 500 leg ulcer patients.

Many patients had previous surgery with skin grafting and vein stripping. But our two-step protocol provided more effective healing. This is because the treatment is directed at the underlying cause, the venous pump failure.

For information on how your patients can benefit from this treatment call Louis Ivey, MD, Eastern Region Medical Director at (301) 654-6633.



After 17 days of isometric dressing application, ulcer is responding.



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A#

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Of all the H₂-receptor antagonists, only Axid heals and relieves reflux esophagitis at its standard duodenal ulcer dosage. Axid, **150** mg b.i.d., relieves heartburn in **86%** of patients after one day and **93%** after one week.¹

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150 mg b.i.d.

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AXID[®]

nizatidine capsules

Brief Summary. Consult the package insert for complete prescribing information.

Indications and Usage: 1. *Active duodenal ulcer*—for up to 8 weeks of treatment at a dosage of 300 mg h.s. or 150 mg b.i.d. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a dosage of 150 mg h.s. at bedtime. The consequences of therapy with Axid for longer than 1 year are not known.

3. *Gastroesophageal reflux disease (GERD)*—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

Contraindication: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H₂-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H₂-receptor antagonists.

Precautions: General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix[®] may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproductive capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

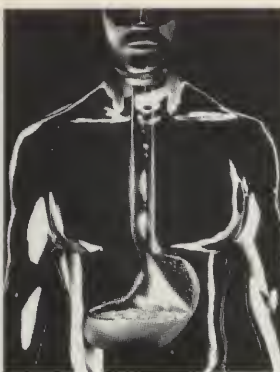
Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method. PV 2093 AMP [101591]

Additional information available to the profession on request.



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LETTERS TO THE EDITOR LETTERS TO THE

Lend your shoulder

"If I have seen further, it is by standing on the shoulders of giants." So wrote Isaac Newton to Robert Hooke in 1676. Newton obtained his enthusiasm for optics and geometry from his mentor, Isaac Barrow, and was also greatly indebted to Galileo, Kepler, and Descartes. In time, the shoulder of Newtonian physics with its independent time and three-dimensional space would be offered to Einstein who gave new color to mathematical physics and reached forward into the uncharted areas of related space and time. Without the system of Newton, Einstein might not have given us relativity.

Did you know that Newton had a great part in inventing calculus, constructed telescopes, studied light and its refraction, was an astronomer, worked out the principles of gravitation, and was a Master of the Mint? He was a scientist, member of the Royal Society, and sat in Parliament. This portion of his life does not reveal the whole man, however, because the public does not know that his writings in theology would have produced the equivalent of seventeen volumes of average size today.

Newton was a reluctant writer and, upon occasion, had to be urged to put his ideas into print. What a loss civilization might have incurred had he not published!

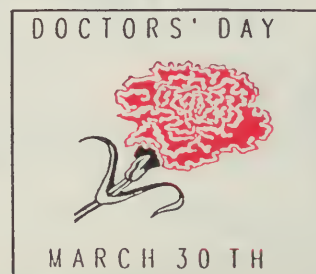
You may not be a Newton, but you can read, study and write. Although you may not provide a sturdy shoulder to someone in the future, you might offer a little help. Do not give your writing the cold shoulder. Submit an article to the *Maryland Medical Journal*.

JOSEPH M. MILLER, M.D.
Timonium

National Doctors' Day

To show appreciation for the invaluable contribution physicians make in caring for the sick, advancing medical knowledge, and promoting improved public health, March 30th has been declared National Doctors' Day; its official symbol is the red carnation.

March 30 was chosen as the official day on which to celebrate Doctors' Day, since it was on that day in 1842 that Dr. Crawford W. Long of Jefferson, Georgia, became the first physician in history to use ether anesthesia in surgery.





David Paul, MD – 1st Place Color, 1991 – "Wars End"

Enter the Twelfth Annual Med Chi Photo Contest

Deadline for entries is Friday, April 3, 1992 ● Two categories: Black & White or Color ● Open to all Med Chi and Auxiliary Members ● First and Second Prizes Awarded In Each Category ● All Photographs will be displayed at the 1992 Annual Meeting at the Omni Inner Harbor Hotel in Baltimore.

Photo Contest Rules

- Eligibility:** All members of the Faculty and members of the Auxiliary to the Medical and Chirurgical Faculty may enter. Professional photographers may not enter. Members of the Photo Contest Committee and their families are not eligible.
1. Photographs may be submitted in two categories: black and white or color.
 2. Limit: three entries per person.
 3. Prints only, no smaller than 8 x 10" or larger than 11 x 14", will be accepted. If your favorite shot is a slide, you must have a print made within these size ranges to enter the contest.
 4. Entries must be matted or dry mounted. No framed photographs will be accepted.
 5. Entries must have name, address, and telephone number attached to the back of each photograph.
 6. Entries may be mailed or brought to Med Chi, 1211 Cathedral Street, Baltimore, Maryland 21201 by the close of the business day on April 3.
 7. Photographs entered in the contest will be on display at the 1992 Annual Meeting.
 8. Prizes will be awarded to the first and second place winners.
 9. Winners will be announced at the Annual Meeting of the Medical and Chirurgical Faculty, April 30 – May 2, 1992.
 10. Photographs will not be mailed back. Photographs may be claimed at the exhibit area at the close of the Annual Meeting at noon on May 2, or at Med Chi thereafter.
 11. Med Chi does not guarantee against loss or damage of any kind to the photographs submitted to the contest.

Manuscripts may be sent to Editor, *MMJ*, 1211 Cathedral St., Baltimore, MD 21201. Articles are accepted for publication on the condition that they are contributed solely to this journal. Transmittal letters should designate one author as correspondent and include his/her address and telephone number. Manuscripts are reviewed by editorial board members and guest reviewers.

Specifications

Manuscripts must be original typed copy, double-spaced throughout (including text, case reports, legends, tables, and references) with pages numbered consecutively. Along with manuscripts, please send an IBM-compatible floppy disk, with the document entered in a WordPerfect or ASCII format.

Include full name of author(s) with highest degrees and academic or professional titles.

Tables with brief descriptive titles are to be typed on separate sheets of paper and numbered. The Editor reserves the right to edit tables. Statistics must be consistent in both tables and text.

An introductory synopsis of approximately 25 to 50 words is required.

References are limited to those citations noted in the text and are to be typed double-spaced and numbered consecutively as they appear in the text. The number of

references generally is limited to 20 in major contributions and fewer in shorter articles. Personal communications and unpublished data should not be included.

Photographic material must be submitted as high-contrast glossy prints. Drawings and graphs must be of professional quality. Recognizable photos of patients are to be masked and should carry with them written permission for publication.

For more extensive information about preparing medical articles for publication, see the *Uniform Requirements for Manuscripts Submitted to Biomedical Journals* compiled by the International Committee on Medical Journal Editors (available through the *Annals of Internal Medicine*).

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TOUGH, SMART AND YOURS

medical
economics
JUNE 1991

Successfully defending a brain-damaged baby case is the courtroom equivalent of pitching a no-hitter. Because the "sympathy factor" can add millions to a jury's award, many insurance carriers would rather settle than fight.

Not so the P-I-E Mutual Insurance Co. of Cleveland, Ohio, and the 4-year-old law firm—Jacobson, Maynard, Tuschman & Kalur—that does all its defense work. In 21 brain-damaged baby cases it has defended for the doctor-owned company, its record is a remarkable 19-1, the last a hung jury. In 1988, its overall record read 31 wins, 5 losses—all malpractice cases.

There's more to these numbers than luck, "the even legal skill" adds JMT&K founding partner Aaron Jacobson, who was one of Ohio's leading plaintiffs' lawyers before he, Larry E. Rogers, Herbert S. Bell, M.D., and 50 other Cleveland doctors formed P-I-E in 1975.

"It's the concept behind the firm that makes it work. Physicians' panels review every case specially panel reviews every defendant to decide whether the defendant deviated significantly from the standard of care. If he did, we pay. If he didn't, we defend. Makes no difference whether it's a \$5,000 or a \$5 million case. We label it 'No pay.' That policy has resulted in a lot of cases being dropped. Perhaps more important, it's

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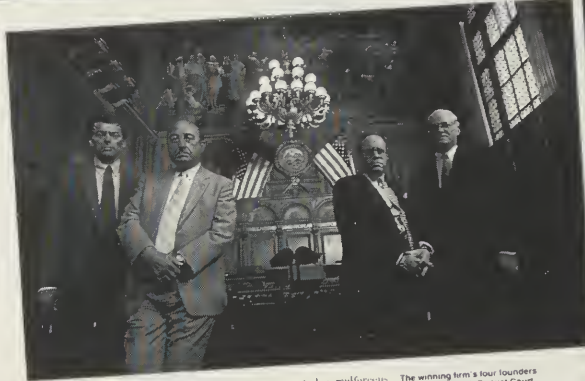
By Howard Eisenberg

discouraged the filing of many other cases. Plaintiffs' attorneys have learned that we're fair negotiators when our doctor's in the wrong, but won't back down when he's right."

That approach pays off. "According to the most recent report I've seen from the General Accounting Office," says Larry Rogers, P-I-E president and CEO, "in 1984, about 75 percent of medical malpractice claims were closed without payment. Through 1988, we've closed an average of 78 percent of our cases without a dime changing hands. And it's my understanding that, without including defense costs, St. Paul Fire and Marine Insurance Co.'s 1988 average gross payout for cases closed in Ohio with payment was \$52,500. Our comparable figure was about \$10,000 below

theirs. That's partly why we can sell an OBG specialist in Ohio—an industrial state that ranks among the most litigious—\$1.2 million in coverage for just \$25,400."

The unique marriage of P-I-E and JMT&K has been so successful that the carrier has expanded into five other states: Indiana, Kentucky, Maryland, Missouri, and West Virginia. Where P-I-E goes, there goes JMT&K, with nine branches of trial attorneys, and may well be the nation's largest devoted well-versed exclusively to medical malpractice-defense symbiosis. If duplicated by other doctor companies, make a significant contribution to reducing malpractice litigation nationwide? An up-close look at



box, JMT&K operates may help to answer that question.

Every lawyer develops a medical specialty

"Our firm's lawyers read more medical books than law books," says P-I-E Vice President Gerard C. Oppenorth, himself a veteran defense attorney. Robert Maynard explains, "New cases are discussed at our weekly staff meeting, so that every lawyer is familiar with every case. But we assign cases to our attorneys according to medical specialty. They're well-versed in their fields, so they don't have to reinvent the wheel with each case." Last year, the firm's OBG specialist, attorney Jerome S. Kalur, who had won 16 consecutive brain-damaged baby cases, faced one of his toughest challenges when he defended a GP

who attempted a midforceps delivery that ended in a Caesar section and a severely brain-injured baby. Recalls Kalur, "I didn't think the doctor had caused the damage, but our position was weakened by the fact that he didn't have midforceps privileges. Based on that departure from the standard of care, our doctor panel voted to settle, and, since the hospital was also involved, a combined sum of \$1.5 million was offered. Plaintiffs turned us down flat."

"I wanted to depose the doctor, who'd been involved in the mother's care during her hospitalization, but the attorney for the plaintiff baby insisted it would violate the mother's physician-patient confidentiality. That privilege would terminate automatically when her medical

The winning firm's four founders at Cleveland's 8th District Court of Appeals (from left): Jerome S. Kalur, Aaron Jacobson, James M. Tuschman, and Robert Maynard.

records were introduced at the trial end of the plaintiff's case. Meanwhile, I was in the no-win position of having to tell the jury, 'It couldn't have been the midforceps,' without offering them another reasonable brain-damage theory."

Fortunately, the plaintiffs rested their case on a Friday afternoon, giving JMT&K time for a weekend rally. "Twenty minutes later," says Kalur, "I was in the hospital pathologist's office with an order permitting me to view the mother's placental slides." Meconium staining had been charted, and Kalur had a hunch that fetal distress had begun long before the for-

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^{99m}Techetium dimercaptosuccinic acid scan in evaluating patients with urinary tract infection

Fred J. Heldrich, M.D.

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In clinical practice, determining which patients with urinary tract infection have upper urinary tract involvement is difficult yet important for proper management. This report indicates that the ^{99m}technetium dimercaptosuccinic acid (DMSA) scan is a useful test in making this determination.

To properly manage patients with urinary tract infection (UTI), it is important to determine if the renal parenchyma is involved or if the infection is confined to the lower urinary tract. Tests commonly performed on specimens of blood and urine to make this determination lack specificity and sensitivity in the pediatric population.^{1,2} The diagnostic imaging techniques of nuclear scanning with ^{99m}technetium dimercaptosuccinic acid (DMSA) and intravenous pyelography (IVP) or renal sonography (SONO) were used to identify patients with upper urinary tract infections. This report compares the results of these imaging studies. Positive findings by IVP were dilatation of the pelvis or ureters, cortical thinning, calyceal blunting, a double collecting system, abnormally positioned kidneys, or decreased uptake of the contrast material. Positive findings by sonography were abnormally positioned kidneys or dilatation of the collecting system. The DMSA scans, performed three hours postinjection with the views obtained in the posterior, left posterior oblique (LPO), and right posterior oblique (RPO), were positive if cortical defects of isotopic concentration were noted.

Methods

The records of fifty-one patients with urinary tract infection, who were followed in the renal clinic at St. Agnes Hospital, were reviewed. Diagnosis of urinary tract infection was established by the bacterial colony count per cubic centimeter (col/cc) of urine. A colony count of $\geq 100,000$ col/cc in a clean caught midstream specimen, of $\geq 1,000$ col/cc in a catheterized specimen, or of any growth in a suprapubic specimen, were the criteria used. Patients were evaluated by intravenous pyelogram or renal sonogram plus a DMSA scan within a week of making the diagnosis of urinary tract infection. The results of these studies were tabulated and compared. Although each patient also had a voiding cystourethrogram (VCUG) performed, the results were not included because VCUGs do not differentiate patients with upper urinary tract infection from those with

lower tract infection. Patients' ages ranged from one month to 18 years. There were four males and forty-seven females. Although all patients were being seen by us for the first time, all were not experiencing their first urinary tract infection.

Results

The results of these imaging studies are summarized in the Table. Of the fifty-one patients, twenty-five had positive studies by IVP and/or renal sonogram and DMSA scan. Seventeen patients had positive DMSA scans only. Nine patients had positive IVP or renal sonograms only. Five of these nine patients demonstrated fullness of the renal pelvis, which may or may not indicate infection in the pelvis of the kidney, but not necessarily the renal parenchyma. Four of the nine patients had either a pelvic kidney, double ureter, Hutch diverticulum, or horseshoe kidney, but none of these findings are indicative of infection *per se*.

Discussion

Reported rates of recurrence of urinary tract infection in pediatric patients are high. A recurrence rate of 30 percent following the first urinary tract infection, with higher recurrence rates following subsequent infections, has been reported. A rate as high as 75 percent has been reported following three or more episodes.³ Better means of identifying, evaluating, and treating patients with urinary tract infections may reduce this high rate of recurrence.

Multiple factors determine the success of therapy in patients with urinary tract infections. These include structural abnormalities of the genitourinary tract; host defense mechanisms; and selection, dosage, and compliance in taking the medication. Microbiologic factors include the organism's ability to attach and invade tissue, to resist natural defense mechanisms of the host, or to resist the antibiotic chosen.^{4,5} There is also evidence that results of therapy may vary with the location of the infection (*i.e.*, upper tract versus lower tract) and the duration of treatment.⁶

While recurrent infection is not desirable, infections involving only the lower urinary tract are less cause for concern. Infections of the upper urinary tract are of greater concern because damage to the renal parenchyma may lead to complications such as a reduction in renal function, hypertension, or septicemia during the acute stage of infection.

There are no clinical signs or symptoms that clearly identify patients with upper urinary tract infection. Even patients

with asymptomatic bacteriuria may have upper urinary tract involvement.⁷ Laboratory methods used to differentiate between upper and lower urinary tract infection, such as measurements of renal concentrating capacity or glomerular filtration rate; determination of increased urinary excretion of B₂-microglobulin, urinary levels of N-acetyl-B-D-glucosaminidase, and lactic dehydrogenase isoenzyme V; elevation of anti-Tamm-Horsfall antibodies or the presence of antibody-coated bacteria in the urine; fever; or an elevated C-reactive protein or elevated erythrocyte sedimentation rate, all lack sensitivity or specificity in pediatric patients.^{1,2}

Urine may be obtained from the upper urinary tract by ureteral catheterization or the bladder washout technique; however, anesthesia is required, and neither study is practical for use in the majority of pediatric patients who are diagnosed, evaluated, and managed on an ambulatory basis. Although a biopsy obtained from infected renal parenchyma is the ultimate diagnostic procedure, it is not an ambulatory procedure; and, to be reliable, the aspirate must be obtained from the area of the kidney that is infected. IVP or sonography may document abnormalities of renal tissue as a result of infection but not necessarily an acute infection.

A positive DMSA scan indicates impaired tubular function. This finding is consistent with acute pyelonephritis, but may also be a permanent finding as a result of a past infection.^{8,9}

While the sensitivity of these imaging techniques has not been evaluated against positive bacterial cultures obtained from the renal parenchyma, they do identify upper urinary tract abnormalities consistent with an upper urinary tract infection. The structural abnormalities caused by infection, which are often observed by IVP or sonography, require significant damage to the renal parenchyma (*e.g.*, cortical thinning or calyceal blunting). The DMSA scan identifies functional abnormalities of tubular function consistent with pyelonephritis, either acute or chronic, not always detected by IVP or sonography.

Our findings, obtained in patients soon after diagnosing an acute urinary tract infection, indicate that the DMSA scan is a superior imaging technique for identifying patients with upper urinary tract involvement (Figure 1).

It is our custom to treat patients with vesicoureteral reflux with antibiotics to maintain sterility of the urine, anticipating that the reflux will eventually cease, and the renal parenchyma will be protected. In addition to providing an initial assessment of renal damage, the DMSA scan offers a means to determine if the upper tract becomes infected, or if there is extension of existing renal damage during the period of antibiotic therapy while reflux is present. Likewise, successful management of an upper urinary tract infection may be documented by a DMSA scan that reverts to normal or improves significantly after therapy (Figure 2).

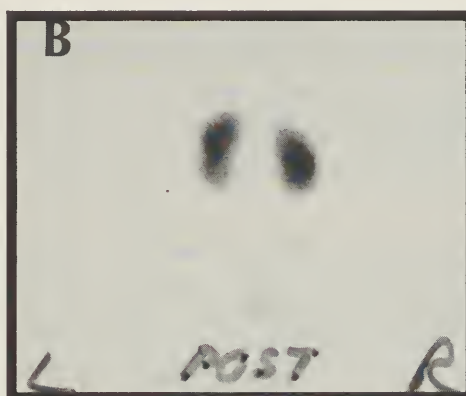
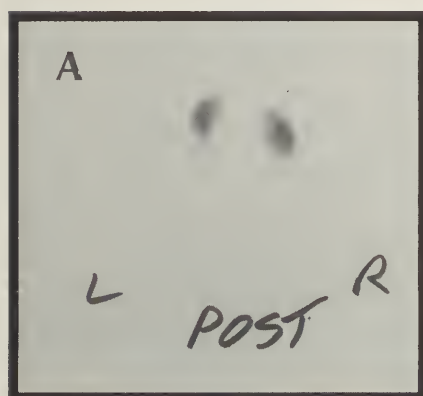
Our policy has been to perform a renal sonogram or IVP plus a voiding cystourethrogram on all pediatric patients with a culture-proven urinary tract infection if these studies have

Table. Results of imaging studies in patients with urinary tract infection

Positive studies	Patients (N=51)
IVP or SONO & DMSA	25
DMSA only	17
IVP or SONO only	9
Hutch diverticulum	(1/9)
Pelvic kidney	(1/9)
Double ureter	(1/9)
Horseshoe kidney	(1/9)
Renal pelvis fullness	(5/9)



Figure 1. DMSA scan of a patient with an acute UTI taken three hours postinjection of the isotope. There is reduced concentration in the cortex of the superior pole of the left kidney.



Figures 2A & 2B. Comparison of DMSA scans of a patient with UTI taken several days after diagnosis (A) and six months later, after completion of antibiotic therapy (B). The films differ in overall density due to a difference in developing technique; however, there is significant improvement in isotope uptake noted especially in the lower pole of the left kidney.

not previously been performed. As a result of our experience, we now include the DMSA scan as part of the initial imaging studies for most patients, but routinely for those less than five years of age; those with a positive renal sonogram, IVP or VCUG; or those with the clinical signs and symptoms suggestive of infection of the upper urinary tract.

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Complications of operative and endoscopic gastrostomies

Jeanette Linder, M.D. and E. George Elias, M.D., Ph.D.

Dr. Linder is a resident in the Department of Radiation Oncology, University of Maryland Hospital, and Dr. Elias is director of the Surgical Oncology Program and professor of surgery and oncology, University of Maryland School of Medicine, Baltimore, MD. Reprints: E. George Elias, M.D., Surgical Oncology Program, University of Maryland Hospital, Room #N13E02, Baltimore, MD 21201.

In a retrospective study of fifty cases of gastrostomy insertion performed operatively (OG) or using a percutaneous endoscopic approach (PEG), complication rates were 74 percent (nineteen adults) and 76 percent (seventeen children) in the OG group, and 86 percent (fourteen adults) in the PEG group. While most complications were minor, major ones were usually related to the underlying disease and the general condition of the patient.

Controversy exists over the superiority of various techniques of inserting a feeding gastrostomy tube, whether operative or endoscopic.^{1,2} Each procedure has a myriad of potential complications varying in degree from inconsequential to fatal.^{3,4} These sequelae could be related to the technique and to individual patient characteristics in undetermined proportions. A confounding factor in the study and analysis of gastrostomy tube placement is the relative infrequency of this procedure. In an attempt to clarify which procedure was technically superior, we correlated patient characteristics and the type of gastrostomy used. We have also correlated the indications for gastrostomies to the type of procedure.

Materials and methods

Between July 1, 1986 and June 30, 1988, eighty-three patients in our institution underwent placement of feeding gastrostomy tubes. These were placed operatively (OG) or via a percutaneous endoscopic (PEG) approach. We excluded the few cases in which fluoroscopically guided procedures were done. The postoperative complications, up to thirty days after performing the gastrostomies, were compiled from chart reviews and telephone inquiries of patients' family members or caretakers.

Results

Over a two-year period, 13,303 major surgical procedures were performed at our institution. These included 2,445 abdominal procedures, 1,301 thoracic procedures, 9,474 other procedures, and only 83 gastrostomies. A similar proportion of endoscopic procedures included percutaneous-endoscopic gastrostomies. Despite extensive effort, adequate perioperative follow-up was obtained for only fifty patients. These included seventeen operative gastrostomies in the pediatric group and thirty-three in the adult group, of which nineteen were operative and fourteen were inserted via a percutaneous-endoscopic approach. The age

distribution was obviously skewed for the pediatric population, but was fairly close in the adult groups (Table 1).

There were several indications for gastrostomy tube placement. We divided these into three main categories: anatomic, functional, and miscellaneous. Fifty percent were performed for anatomic indications such as alimentary tract obstruction by tumors, strictures, or developmental abnormalities. Thirty percent were placed for dysfunctional reasons, mostly neuro-motor dysphagia secondary to cerebrovascular accident or hypoxia. The rest were placed for miscellaneous reasons.

There were a total of ninety-seven complications of various magnitudes. There were 37 complications in the adult PEG group, 32 in the adult OG group, and 28 in the pediatric OG group (Table 2). These complications were divided into those related to the procedure and those not related to the procedure. Twelve of fourteen (86 percent) adult PEG cases had complications, as did fourteen of seventeen (82 percent) pediatric OG cases, and fifteen of nineteen (79 percent) adult OG cases. There were no statistically significant differences among them. In addition, there were four perioperative deaths divided equally between PEG and OG procedures in adults. The incidence of complications per case was 2.6 in the adult PEG group; 1.7 in the adult OG group; and 1.6 in the pediatric OG group. The morbidity and mortality related to the procedures included (1) five wound related, four gastrostomy tube related, and two deaths in the adult PEG group; (2) two wound related and four tube related in the pediatric OG group; and (3) one tube related and two deaths in the adult OG group. Several other complications that were not considered to be related to the procedures spanned virtually every organ system. There was bias for particular systems, especially gastrointestinal and stoma-related problems in the PEG group. In contrast, patients with surgically placed tubes suffered from gastrointestinal and pulmonary problems.

Further analysis of the data showed that the majority of complications were not related to the actual placement of the gastrostomy tube. Less than one-third of the adults in the PEG group and only 15 percent of the OG patients had procedure-related complications (Table 2).

We also considered whether the operative gastrostomies were performed as the only primary procedure or as part of another concomitant approach. Only 24 percent of the pediatric gastrostomies were done as the sole procedure compared with over half (58 percent) of the adult gastrostomies. While most of the pediatric gastrostomies were performed as concomitant procedures (76 percent), they had only a 64 percent com-

plication rate. On the other hand, 42 percent of the adult operative gastrostomies that were done during other procedures had a 44 percent complication rate.

Complication rates varied slightly when correlated to the indications and requirements for gastrostomy tube placement. Tubes placed for anatomic reasons had fairly similar incidences, whether they were placed operatively or endoscopically. Those placed for dysfunctional indications tended to have the most complications in the pediatric operative group, with an incidence of 3.5 per case. There was a propensity for complications when tubes were placed for miscellaneous reasons in the adult PEG group, resulting in an incidence of 3.8 per case (Table 3).

Discussion

Insertions of gastrostomy tubes are not frequent procedures. Operative gastrostomies constituted 3.3 percent of all abdominal surgery and 0.6 percent of all surgical procedures in a two-year period in our institution. This did not provide large numbers for intense study. Additional difficulties inherent in the review of such cases included the high frequency of incomplete follow-up. Loss of follow-up was attributed to factors ranging from placement in geographically distant facilities to discharge to homes with relatively unsophisticated caretakers and poor historians. These factors were substantially magnified in our predominantly inner city catchment population. Furthermore, of the eighty-three patients who underwent placement of feeding gastrostomies, complete information was available for only fifty patients up to thirty days postoperatively.

The nature of a retrospective study includes the difficulty of determining the chronologic sequence of events. This information is necessary to know when pairing values for analysis. The unavailability of this information explains the lack of p-values for statistical significance.

Overall, the placement of feeding gastrostomies was not a mild or benign procedure. Neither operative nor endoscopic techniques were without some complications. Since the majority of the complications were not related to the technique of tube placement itself, we could surmise that most of

Table 1. Age distribution

	Endoscopic Adult	Operative Pediatric	Adult
Range	43-97 years	1 day-4 years	31-86 years
Median	68 years	6 months	59 years

Table 2. Number of complications

Complications	Endoscopic Adult (n=14)	Operative Pediatric (n=17)	Adult (n=19)
Procedure related	11	6	3
Not procedure related	26	22	29
Total	37	28	32

Procedure related = wound infection, leaks around tube, blockage of tube, etc., and four deaths in adults.

Not procedure related = pulmonary, gastrointestinal, cardiovascular, genitourinary, etc.

Table 3. Incidence of complications correlated to indications

	Endoscopic Adult (n=14)	Operative Pediatric (n=17)	Adult (n=19)
Anatomic			
No. of cases	5.0	9.0	11.0
No. of complications	12.0	12.0	21.0
Incidence per case	2.4	1.3	1.9
Functional			
No. of cases	5.0	2.0	8.0
No. of complications	10.0	7.0	11.0
Incidence per case	2.0	3.5	1.4
Miscellaneous			
No. of cases	4.0	6.0	0.0
No. of complications	15.0	9.0	0.0
Incidence per case	3.8	1.5	0.0

the problems tend to be related to the patients' primary diseases and general habitus. Since all groups had incidences of complications greater than the number of cases, we could expect a patient with one complication to develop more problems.

We have attempted to use our data to aid in selecting the type of procedures that could minimize the complication rates to a certain patient, considering advantages specific to the techniques themselves. For example, due to the size of the scopes, it is not feasible to use them in very young patients. Furthermore, there are certain anatomic variants that contraindicate endoscopic placement: patients with hypopharyngeal or esophageal tumors that would not allow the scope to pass through safely; patients with organomegaly or large tumors that obscure the gastric pouch; and some patients with previous left upper quadrant abdominal surgery in whom loops of small or large bowel may be interpositioned between the anterior abdominal wall and the stomach. In such cases, the typical location of the stomach, its mobility, or even its accessibility might not be amenable to endoscopic placement. On the other hand, PEG may be considered and carried out concomitantly in patients who are undergoing upper gastrointestinal endoscopy. Similarly, patients who are undergoing surgery for other reasons could have operative placement of the gastrostomy tube at the same time, obviating the need for a second procedure. Furthermore, patients with pulmonary problems may best be served by PEG since the PEG group in our study had fewer respiratory complications than the operative group.

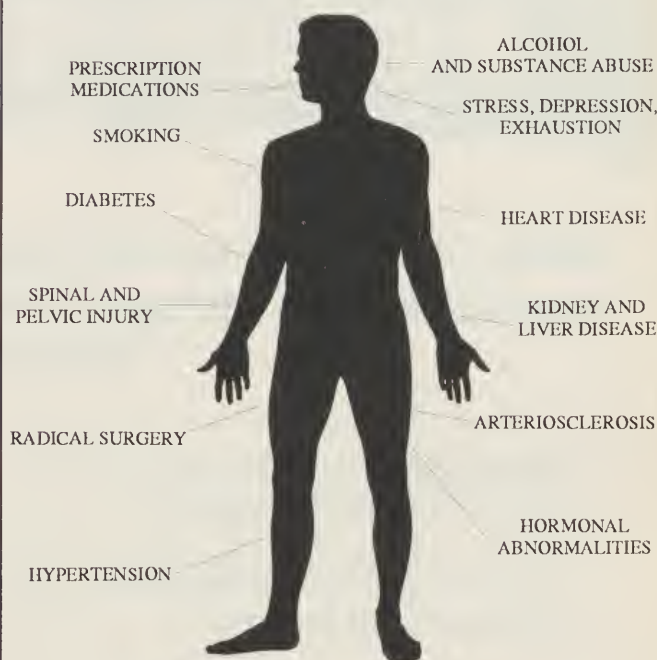
In the unlikely situation that all other variables are equal, endoscopic procedures are usually less costly than the operative ones. In addition, PEGs are performed under light intravenous sedation with no need for general or high spinal anesthesia.

Considering the general condition of the patient, which is always important, one needs to determine the nutritional and surgical risk for each patient early on in the course of his illness. Early recognition and replacement of nutritional deficiencies via parenteral means can maximize recovery once the enteral route is re-established, regardless of the type of tube chosen. We must also keep in mind that parenteral alimentations are better than intravenous hyperalimentation as they are more natural, carry less serious complications, and, overall, are less costly.

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Strategies to reduce the high cost of patient noncompliance

Diane L. McNally, B.S. Pharm. and Debra Wertheimer, M.D.

From the University of Maryland at Baltimore where Ms. McNally is a pharmacist in the Department of Pharmacy Practice and Administration, School of Pharmacy, and Dr. Wertheimer is an internist in the Division of General Internal Medicine and Geriatrics, School of Medicine.

The documented low rate of compliance can result from ineffective communication by the pharmaceutical and medical profession, and poor comprehension of prescription instructions by the public. Presented are several examples of how pharmacists can assist physicians in improving and monitoring their patients' compliance behavior. Strategies to enhance communication through the written prescription are offered.

Noncompliance has become a major concern for practicing physicians, pharmacists, and researchers. Between 1981 and 1985, over 2,500 articles related to compliance appeared in the literature, compared with 500 articles published up to 1975.¹ The estimated average compliance rate for a prescribed regimen is 50 percent; compliance rates for chronic therapy and asymptomatic diseases are even lower.² Noncompliant behavior can be exhibited as either overutilization or underutilization of medication.

Overutilization describes patients who take one or more medications at a higher dose or frequency than prescribed by their physicians. It also describes patients prescribed medications from different doctors who are unaware of the other medications the patients are taking, whether prescription drugs or over-the-counter. For example, Dr. Smith, an orthopaedist, prescribes ibuprofen for his patient's sprained ankle, unaware that Dr. Jones, a rheumatologist, has been prescribing naproxen for the patient's arthritis for the past year.

Underutilization includes taking medications at lower doses or at less frequent intervals than prescribed. If a patient does not fill a prescription or stops taking the medication without authorization by the physician, this is considered underutilization. This problem is often seen with antibiotic therapy; the patient feels better in three days, stops taking his or her medication, and has a relapse two weeks later.

The consequences of noncompliant behavior are not benign. Overutilization of medications can place a person at greater risk for an adverse effect. Underutilization of medicines may result in therapeutic failures leading to an increase in disease severity. In either case, the end result may include increased hospitalizations and medical care expenditures. A recent meta-analysis of seven studies revealed that an overall hospitalization rate of 5.5 percent can be attributed to noncompliance.³ This percentage equals 1.94 million annual hospital admissions, at a cost of 8.5 billion dollars.³

Cardiovascular disease management is one example where the costs

of noncompliance are especially high. Noncompliance by cardiovascular disease patients has been estimated to be a factor in 125,000 deaths and several hundred thousand hospitalizations a year. The calculated cost to society is over \$1.5 billion in lost earnings due to lost workdays.⁴

Unfortunately, identifying the noncompliant patient is very difficult. Studies have shown that physicians tend to overestimate patient adherence to treatment regimens.⁵ A relationship between compliance and gender, socioeconomic status, age (except for the very old and very young), or education has not been found.⁶

So, how can physicians better identify and improve noncompliance in their patients? One answer is with the help of community pharmacists. Because pharmacists have frequent and repeated contact with patients, they are in an excellent position to measure and intervene with noncompliant patients. Most pharmacies in Maryland use computers to fill prescriptions; these computers provide pharmacists with the capability of maintaining patient profiles. The computer alerts the pharmacist when patients refill their prescriptions too soon, identifying possible overutilization. The pharmacist's regular review of patient profiles permits identification of underutilization by those patients who are not regularly refilling their prescriptions.

Effective communication must be maintained between the pharmacist, the physician, and the patient to gain the maximum benefit from this partnership. The primary communication between the pharmacist, patient, and physician is the prescription. When pharmacists dispense prescriptions they have the opportunity to reinforce a physician's directions. Reinforcement through repetition is an effective compliance strategy. But, if the prescription says "as directed" or "as necessary," the opportunity is lost. In addition, these nonspecific directions do not enable the pharmacist to measure compliance as assessed by timeliness of refills.

The imprecision of poorly written directions can also influence a patient's ability to comply. To improve patient recall and reduce administration errors, patients require explicit directions. A high percentage of reported administrative errors are due to the direct failure of patients to comprehend the directions on the prescription label.⁷ If given a prescription for tetracycline 250 mg with the directions, "Take one capsule every six hours," how would you take the medication? In one study, only 36 percent of the sixty-seven participants interpreted the directions to mean around the clock, for a total of four doses in twenty-four hours. Approximately 25 percent would have been noncompliant by omitting the late-night dose because they would have divided the day into three six-hour periods while they were awake.⁸ Although in this instance, the pharmacist has adequate information to counsel the patient, the example demonstrates the importance of prescription writing and labeling. Labeling the prescription with the exact times of day the medication is to be taken, such as 6:00 a.m., 12:00 p.m., 6:00 p.m., and 12:00 a.m., may reduce medication errors. Physicians should keep in mind

that patients will be more compliant if the regimen complements their daily schedule, and if the instructions are easily understood. To improve patient understanding, instructions should be written on the bottle and on an instruction sheet in large enough print for someone who is visually impaired.

Even with well-written prescriptions, it is important for physicians and pharmacists to be accessible for verbal clarification of instructions, particularly at transition points. Discharge from an acute care hospital, long-term care facility, or emergency room often results in new prescriptions. One recent study found that 47 percent of emergency rooms visits lead to the prescribing of at least one additional medication, and in 10 percent of those visits, the new medication added a potential adverse interaction.⁹ Since most physicians who see patients in these settings are not the patients' primary physicians, pharmacists need to review these prescriptions carefully. The pharmacists' assessment may find duplicate medications or potential drug-drug interactions between the new medications and previous medications. Determining whether patients are aware of these possible problems is important. If patients are uncertain if they are to use the old medications as well as the new ones, the pharmacist needs to clarify the problem with the physician. To facilitate the resolution of such a situation, it is important for prescribers to print their names and telephone numbers on all institutional prescription blanks.

Communication between the pharmacist and physician is also crucial when there appear to be multiple prescribers. Often patients may see many specialists, increasing the opportunity for serious iatrogenic complications. If a patient patronizes a single pharmacy, the pharmacist has the ability to review the medication profile and prevent any possible iatrogenic problems.

With the growing number of new drugs on the market, the importance of identifying the symptom, indication, or intended effect is amplified. This additional information allows pharmacists to assess compliance and reinforce the physician's instructions. An example is propranolol, which may be used to treat high blood pressure or migraine headaches. It would be nonsensical for a pharmacist to explain how important it is for a patient to take the medication to control high blood pressure even though the patient is not experiencing symptoms, when the patient is being treated for migraine headaches. Knowing the intent of the treatment will aid the pharmacist in communicating with the patient and providing feedback for the physician.

Along with the proliferation of new drugs, there is the issue of higher prices. Over the last decade, the price of drugs has risen faster than the Consumer Price Index.¹⁰ The high cost of medication may be an important factor in determining if some patients will have a prescription filled. Many physicians learn of the latest therapies through contact with drug manufacturer representatives and through the use of samples. However, during the marketing of these medications, the cost is rarely relayed to the physician. Physicians can make use of

community pharmacists as a resource for this information. Pharmacists should alert physicians to the price differential between new drugs and similar older drugs that may be as effective and much less costly. Though a patient's health insurance may cover prescription drugs, health professionals must be cognizant that someone is paying for them (an employer or taxpayers), and select the most cost-effective therapy for that particular patient.

The documented low rate of compliance can result from ineffective communication by the pharmaceutical and medical profession, and poor comprehension of prescription instructions by the public. It is the responsibility of both professions to communicate explicit and appropriate instructions in order to promote compliance and therapeutic outcomes. Improving prescription writing to enhance communication between prescriber, pharmacist, and patient is one strategy. This strategy includes (1) specifying the exact time of day the drug should be administered; (2) including symptoms, indications, or intended effects of the drug; (3) expressing the time period or exact number of refills the prescription may be filled, instead of using *prn*; (4) using generic nomenclature to allow for substitution of less expensive brands, if appropriate; and (5) not using ambiguous instructions such as "as directed." Pharmacists, in turn, need to provide patients with precise directions for medication use. When the pharmacist believes the prescription order lacks clear directions, the pharmacist should contact the physician and clarify the instructions.

A pharmacist's comprehensive drug knowledge can provide physicians with an accessible and indispensable resource. Physicians can obtain unbiased drug information and drug costs from pharmacists. With the help of pharmacists, physicians can better evaluate the drug-taking behavior of their patients, possibly avoiding unnecessary adverse events. Physicians and pharmacists, working together, can improve patient compliance and health outcomes. If, as the studies suggest, half the population is noncompliant and the result is increased health care expenditures, a joint effort using the suggested strategies will have a significant impact on increasing the cost-effectiveness of prescription drug use.

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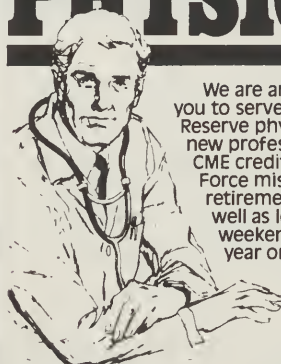
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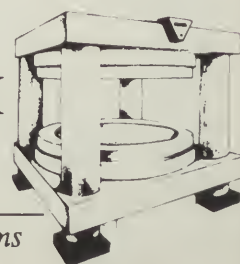
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Community hospital implementation of intraaortic balloon pump therapy for complicated myocardial infarction

Daniel I. Woronow, M.D., F.A.C.C.

Dr. Woronow is assistant clinical professor of medicine, George Washington University School of Medicine and attending cardiologist, Holy Cross and Suburban Hospitals.

The intraaortic balloon counterpulsation pump (IABP) has become standard equipment in many community hospitals. Its major role is to support the failing myocardium, and it may also be used to control refractory ventricular dysrhythmia of ischemic origin. The IABP affords stabilization and subsequent transport of complicated myocardial infarction patients who require more definitive therapies. An example is presented of community hospital implementation of IABP in the presence of thrombolytic therapy.

The intraaortic balloon pump may be employed in the community hospital setting to stabilize complicated acute myocardial infarction, even in the presence of thrombolytic therapy.

Case history

A 47-year-old male was referred to the Suburban Hospital emergency room after two hours of substernal chest pain. An exercise tolerance test had been performed one month earlier for mild exertional chest pain, and reportedly was normal. The patient's father had died at age 55 of a myocardial infarction.

The patient was pale and diaphoretic when he arrived by ambulance. His initial blood pressure was 140/100 mm Hg with a pulse of 84 bpm. His electrocardiogram was indicative of an acute inferior wall myocardial infarction (**Figure 1**). Frequent premature ventricular complexes and short salvos of ventricular tachycardia were noted. A 2 mg/min lidocaine infusion was started after a 75 mg bolus. An infusion of tissue plasminogen activator was started, in addition to intravenous heparin therapy. Two minutes later, the patient developed complete heart block, and within seconds, progressed to ventricular fibrillation. Sinus rhythm was restored after cardioversion with 300 watt-seconds, and an additional 50 mg bolus of lidocaine. Multiple recurrences of ventricular fibrillation required four rapid sequences of cardioversion despite a cumulative lidocaine loading dose of 225 mg. The patient rapidly regained consciousness after each successive defibrillation. Serum chemistries and pH were normal. Recurrences of sustained ventricular tachycardia remained unabated despite lidocaine and bretylium infusions.

Angioplasty facilities were not immediately available. Overdrive ventricular pacing with a transvenous lead had no apparent effect on the

ventricular arrhythmia. An IABP was inserted with one-to-one augmentation. There was immediate cessation of ventricular ectopy with the onset of counterpulsation.

With stabilization, and two hours after hospital presentation, the patient was emergently transported by helicopter to the Washington Hospital Center. Coronary arteriography demonstrated nonocclusive plaque rupture with residual

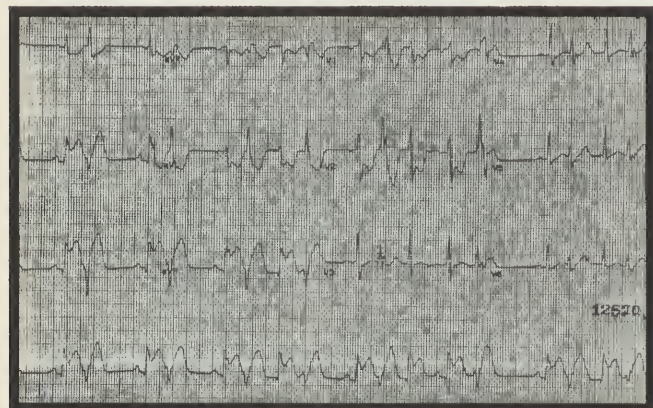


Figure 1. Initial electrocardiogram showing acute inferior infarction pattern with premature ventricular complexes.

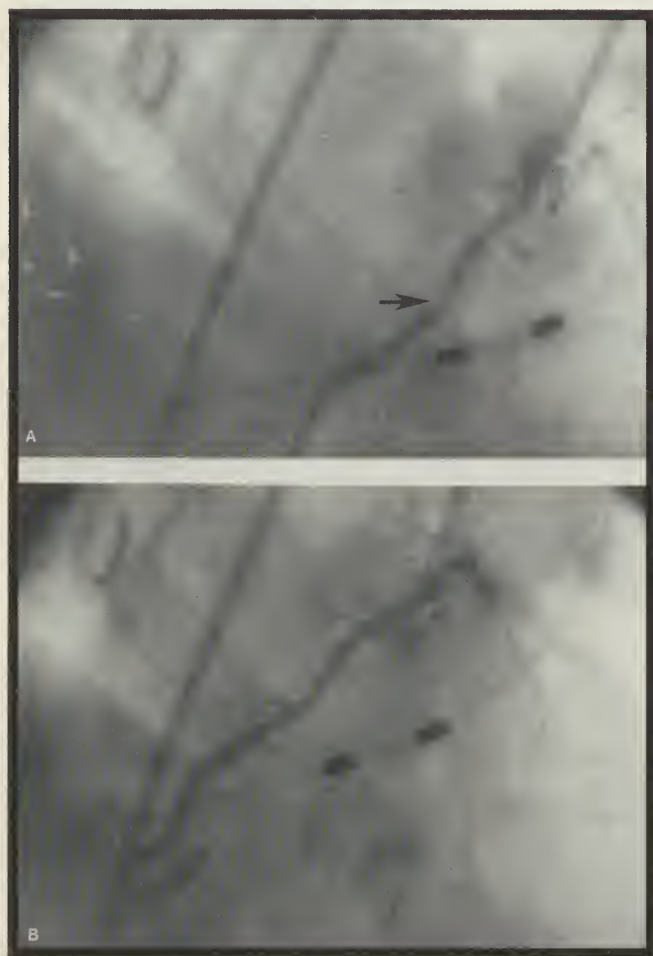


Figure 2. A. Angiogram in right anterior oblique projection of right coronary artery showing high-grade ulcerated stenosis (arrow). B. Same artery shows improved patency after percutaneous transluminal coronary angioplasty.

thrombus in the midright coronary artery (**Figure 2**). There was TIMI (thrombolysis in myocardial infarction) grade II arterial patency. Intracoronary urokinase, 250,000 units, was administered. The residual stenosis was treated with coronary angioplasty. Left ventriculography demonstrated an extensive area of inferoapical hypokinesis with an overall ejection fraction of 40 percent. Creatine kinase (CK) peaked at 2,500 IU with an early washout pattern. IABP and antiarrhythmic therapy were rapidly weaned. The patient had an uneventful recovery and had no hemorrhagic complications or difficulties associated with IABP. He was discharged from the hospital eight days after initial presentation. He remains well, with an angiographically patent artery, six months after presentation.

Discussion

Beneficial effects of the IABP during thrombolytic administration appeared to play a critical role in attaining rhythm stabilization in this patient. Primary ventricular fibrillation may be seen in 10 percent of patients hospitalized for acute myocardial infarction.¹ Conversely, arrhythmias associated with myocardial reperfusion rarely degenerate into ventricular fibrillation.² Postinfarction ventricular arrhythmias remain an uncommon indication for IABP insertion.³ Hanson et al noted that postinfarction ventricular arrhythmias were the primary indication for IABP insertion in only 2.2 percent of all insertions at the Massachusetts General Hospital between 1968 and 1978.⁴ Ventricular arrhythmias improved in 86 percent and were completely abolished in 55 percent of all such patients with IABP. Only eleven of twenty-one had concomitant hypotension as an indication. Multiple mechanisms have been postulated for the utility of IABP in acute myocardial infarction. The most reproducible benefit is reduction of afterload resulting in decreased myocardial oxygen demand.⁵ Attempts to document augmented myocardial perfusion have been disappointing.⁶

Community hospital implementation of the IABP for complicated myocardial infarction remains relevant in the era of thrombolytic therapy. IABP is widely available and does not require the in-hospital support of a cardiac surgical program. Therefore, IABP should be considered as a bridge to more specific cardiac intervention in patients presenting with unstable hemodynamics or refractory ventricular dysrhythmia in the setting of acute myocardial infarction.

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Hypertriglyceridemia: Severe Type V hyperlipidemia in a young woman

Rudolf Titanji, M.D. and Aldo Paz-Guevara, M.D.

From St. Agnes Hospital, Baltimore, MD where Dr. Titanji is a resident in medicine, and Dr. Paz-Guevara is a senior staff member, Department of Medicine and a consultant in endocrinology.

The female patient, a 32-year-old part-time bartender, consulted a dermatologist because she had noted the appearance of yellowish pruritic bumps on her legs, buttocks, and arms. There was no abdominal pain. She had a ten-year history of beer consumption averaging about four cans a day and a five-year history of contraceptive pill use. She had a liberal intake of fats and carbohydrates in her diet. Her family history was positive for diabetes mellitus and coronary artery disease in her grandparents and cirrhosis of the liver in her father. There was no known family history of hyperlipidemia.

Pertinent physical findings included a moderately obese white female weighing 81.5 kg with a height of 1.67 m and a blood pressure of 125/98 mm Hg. Her skin revealed eruptive xanthomata on thighs, back, buttocks, and arms. The fundoscopic examination showed lipemia retinalis. The liver edge was palpable about 1 cm below the right costal margin.

Significant laboratory data. Plasma refrigerated overnight in a tube containing calcium edetate showed a creamy appearance with massive accumulation of chylomicrons in the top of the tube and a turbid infranant layer. Fasting triglycerides were 7,328 mg/dl (normal: 20 to 140 mg/dl); cholesterol was 1,184 mg/dl (desirable levels <200 mg/dl); and gamma glutaryl transferase was 41 IU/dl (normal: 0 to 13 IU/dl). Other liver function tests, as well as serum electrolytes, creatinine, proteins, thyroid function tests, urinalysis, and electrocardiogram, were normal.

The patient was diagnosed as having Type V hyperlipidemia and treated with a dietary regimen of 1,000 calories per day containing 300 mg of cholesterol and 10 percent saturated fats. Alcohol and oral contraceptives were discontinued and 600 mg gemfibrozil p.o. twice a day was prescribed. Three weeks later, the fasting triglyceride levels came down to 54 mg/dl and the total cholesterol to 176 mg/dl. Ten weeks later, the xanthomata cleared completely. The patient did not develop pancreatitis.

Lipoprotein metabolism and transport

Lipoproteins are spherical particles that transport nonpolar lipids through the plasma. Each lipoprotein particle is composed of a *core* that

We present a patient with the typical clinical and biochemical features of severe Type V hyperlipidemia associated with alcohol consumption and estrogen use. Prompt medical intervention resulted in normalization of her lipid profile. We review the lipoprotein composition, the role of lipoproteins in lipid transport with special emphasis on triglycerides, and the clinical features, pathogenesis, and management of Type V hyperlipidemia.

accounts for most of the mass, an oil droplet composed of triglycerides and cholesteryl esters, a *surface coat* of phospholipids, and unesterified cholesterol. Lipoproteins are directed to metabolic sites by apoproteins; these are carrier proteins attached to the particle's surface.¹

Triglycerides are chemically composed of three fatty acids attached to a glycerol molecule. Differences in density have led to the separation of lipoproteins into chylomicrons, very low density lipoproteins (VLDL), low-density lipoproteins (LDL), and high-density lipoproteins (HDL). Chylomicrons remain at the top of the ultracentrifuge; they are very low density lipoproteins, larger than 1,000 Å (Angstroms) in diameter. Their core consists almost entirely of triglycerides. In lipoprotein electrophoresis, chylomicrons migrate to the origin of the paper.

Lipids can be transported by exogenous or endogenous pathways. The exogenous pathway involves the transport of dietary fat. When food reaches the intestinal epithelial cells, dietary triglycerides, phospholipids, and cholesterol are broken down by lipases. These constituents are packaged into large triglyceride rich particles—chylomicrons. The chylomicrons are secreted into the lymphatic space and pass into the general circulation for transport to the capillaries of adipose tissue and skeletal muscle. In the blood stream, triglycerides are bound to carrier proteins Apo A-I, A-II, B48, C-I, C-III, and E. In the capillary bed, they are exposed to the enzyme lipoprotein lipase (LPL), which is activated by Apo C-II and responsible for the lipolysis. During this process, chylomicrons lose many of their triglycerides, which are converted to three free fatty acids. The released free fatty acids bind to albumin, pass through the endothelial cells, and are taken up by the adipose tissue, muscle, or liver.

A second process for lipid transport is the endogenous pathway. When a diet contains excess carbohydrates, the liver converts them into fatty acids, esterifies the fatty acids with glycerol to form triglycerides, and secretes them into the general circulation as VLDLs. The VLDL particles contain Apo B-100 which transports the particles to the tissue capillaries where they interact with the LPL. The LPL enzyme converts the VLDL to intermediate density lipoprotein (IDL).

A portion of the IDL particles are catabolized by the liver. The result is the transformation of the IDL particle into cholesterol-rich LDL. The function of LDL is to supply cholesterol to the adrenal cortical cells, lymphocytes, muscle cells, and renal cells.¹

Diagnosis of hyperlipoproteinemia

Hyperlipidemia results from an increase of lipoproteins, cholesterol, or triglycerides. According to the Fredrickson-Levy classification, there are five types of hyperlipoproteinemias. Type V hyperlipidemia is characterized by excessive amounts of chylomicrons and VLDL, which contain increased triglyceride levels and moderate amounts of cholesterol. Type V hyperlipidemia can result from primary or secondary causes. The most frequently recognized secondary

causes include diabetes mellitus, nephrotic syndrome, hypothyroidism, alcohol abuse, and the use of oral contraceptives.

Alcohol causes hyperlipidemia primarily because it inhibits fatty acid oxidation and enhances fatty acid synthesis in the liver. The excess fatty acids are incorporated into hepatic triglycerides. Some of the excess triglycerides accumulate in the liver, producing the enlarged fatty liver of alcoholics. The remainder of the triglycerides are secreted into plasma, resulting in increased VLDL levels; thus, the plasma concentration of chylomicrons also rises.^{2,3}

The ingestion of estrogen-containing oral contraceptives enhances the VLDL secretion rate from the liver. In most women, this detrimental effect is counteracted by an increase in the catabolism of VLDL, so the net increase in plasma triglycerides is modest. However, in women with an underlying genetic disorder, the ingestion of estrogens can precipitate marked increments of plasma VLDL-triglyceride levels and hyperchylomicronemia. When the latter develops, severe pancreatitis occurs. In addition, the ingestion of oral contraceptives may be a risk factor in promoting thromboembolic disease in young women, particularly those with preexisting hypercholesterolemia. For this reason, it is important to measure the plasma cholesterol and triglyceride levels prior to the institution of birth control pills. The finding of hyperlipidemia is a contraindication to the use of oral contraceptives.²

Clinical and biochemical manifestation of Type V hyperlipidemia

Eruptive xanthomas are believed to be caused by the uptake of lipoproteins by macrophages. The reason they are distributed primarily on the extensor surfaces and the buttocks is unknown.¹ Lipemia retinalis is a curiosity that seldom leads to the diagnosis of hyperlipidemia; rather, it is discovered after an unusual elevation of plasma triglycerides is detected. Neurologic findings such as dementia, memory loss, peripheral neuropathy, and paresthesias have been reported; these manifestations are reversible. Other findings include elevated triglycerides, cholesterol, and chylomicron levels in blood; fatty infiltration of the liver is a frequent finding.³

Pancreatitis can be a serious complication of Type V hyperlipidemia. Its diagnosis is difficult because hypertriglyceridemia can interfere with the estimation of serum amylase. Hyperlipidemia can cause pancreatitis, but the opposite has not been demonstrated.^{1,4}

The circulating chylomicrons inflame the pancreas when they pass through its capillaries. Within the capillary lumen, chylomicrons are exposed to small amounts of pancreatic lipase. This causes partial hydrolysis of the triglycerides and phospholipids of the chylomicrons which, in turn, produce toxic products (fatty acids and lysolecithin) that break down the tissue membranes, produce further leakage of lipase, and eventually cause fulminant pancreatitis.^{1,5,6} The exact level of hypertriglyceridemia may not correlate well with pancreatitis. However, patients with triglyceride values over 1,000 mg/dl should be considered at high risk of developing acute

pancreatitis.⁶ Our patient, with levels greater than 7,000 mg/dl, had no evidence of this complication. The reason some people tolerate higher levels of lipids in their blood without developing pancreatitis is not clear, although the genetic factor in determining the lipoprotein pattern of these patients cannot be ruled out.⁶ The atherogenic effect of hypertriglyceridemia is still a subject of controversy. At this time, there are no definitive studies proving that lowering serum triglyceride levels in Type V hyperlipoproteinemia results in a decrease of atherosclerotic complications.⁷

Patients presenting with eruptive xanthomata should be screened for familial or acquired hypertriglyceridemia, particularly those with a history of alcohol abuse, diabetes, or nephrotic syndrome, or those who are taking estrogens. Most patients can be treated on an outpatient basis, except those patients for whom the possibility of pancreatitis is strongly suspected.

When to treat hypertriglyceridemia? The September 1983 Consensus Conference of the National Institutes of Health recommended that triglyceride levels less than 250 should not be treated. However, triglyceride levels in the range of 250 to 500 mg/dl could be a marker of secondary disorders for a subset of patients with genetic forms of hyperlipoproteinemia who are at increased risk and who need specific therapy. Dietary intervention is the primary approach to therapy in these patients, but drugs have a role in selected persons not responding to dietary management.⁸

Treatment of the patient with Type V hyperlipidemia includes withdrawal of the offending agent, such as alcohol or estrogens, and vigorous treatment of the underlying disorder, namely diabetes, hypothyroidism, or nephrotic syndrome. Caloric restriction is required in the obese subject. Drastic weight loss is not advised since plasma triglyceride levels rise rapidly, and pancreatitis can recur during the periods of rapid weight gain that so frequently follow marked weight loss. In the presence of severe chylomicronemia, a very low fat diet (10 to 20 percent of total calories) may be required to prevent pancreatitis. The diet should be low in saturated as well as unsaturated fats. Implementation of a regular exercise program is important. If the above measures fail to bring the triglyceride levels below 1,000 mg/dl, lipid-lowering agents should be tried—nicotinic acid and fibric acids.^{2,8,9,10}

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Acknowledgments

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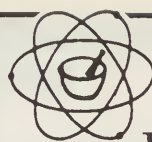
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Gastrointestinal surgery for severe obesity: Summary of the National Institutes of Health consensus statement

More than twelve million people in the United States are severely overweight. About four million are so overweight that their obesity harms their health and well-being, making them candidates for surgical treatment.

People at the highest risk of morbidity and mortality can be categorized as having "clinically severe obesity." The ultimate biologic basis of severe obesity is unknown. The disorder is accompanied by reduced life expectancy, and significant psychosocial and economic problems are frequently experienced by severely obese people. These facts lend urgency to the effort to provide rational care.

Weight reduction may sometimes be achieved through medically-supervised dieting and intensive behavior modification, but when these methods fail, gastrointestinal surgery is a therapeutic option for treating severe obesity. In the last ten to fifteen years, many types of new surgical procedures have been developed, using principles of reduction of gastric volume, intestinal malabsorption, or both. Refinements in these procedures have led to reports of successful results superior to those seen with earlier operations.

In an effort to evaluate the objective evidence for these new techniques, the National Institutes of Health (NIH) held a Consensus Development Conference on Gastrointestinal Surgery for Severe Obesity, March 25–27, 1991. A thirteen-member panel developed a consensus statement after considering scientific presentations and discussions from many physicians, scientists, health care professionals, and others. Following are the panel's conclusions.

Risk for morbidity and mortality accompanying obesity is proportional to the degree of overweight. A simple means to define overweight is by the body mass index (BMI). BMI

is a value derived by dividing one's weight in meters. A BMI value of 40 is roughly equivalent to 100 pounds overweight for an average adult male. Approximately 1.5 million Americans have BMI values over 40. Such patients have clinically severe obesity and are at the highest risk of morbidity and mortality. These patients are potential candidates for treatment by surgical procedures.

Limited success has been achieved by a variety of nonsurgical approaches that include medically-supervised dieting and intensive behavior modification. Very low calorie diets (VLCD) have been widely publicized as having dramatic success in the treatment of clinically severe obesity. However, in the absence of successful behavior modification, long-term maintenance of reduced weight is unlikely, and patients regain most of their weight within one year. These diets alone cannot be considered a reasonable option for achieving permanent weight loss. Combining the VLCD with intensive behavior modification may have more potential as an effective regimen for treating the clinically severe obese patient. Exercise or some form of increased physical activity is recommended as a component of weight-loss programs.

Drug therapy for clinically severe obesity has been disappointing. Although pharmacologic studies with anorexiogenic drugs suggest short-term benefit, prolonged and sustained weight loss has not been proven with these agents. Drugs such as amphetamines and thyroid derivatives are unsafe and unapproved.

Medical complications of rapid weight loss can occur and are usually treatable. Potential problems with electrolyte abnormalities and cardiac arrhythmias during administra-

Gastrointestinal surgery for severe obesity: A response

The Consensus Statement on Gastrointestinal Surgery for Severe Obesity resulted from the third National Institutes of Health (NIH) Consensus Conference held March 25–27, 1991. Specialists in surgery, medicine, gastroenterology, nutrition, epidemiology, psychiatry, and endocrinology addressed five questions: What are the nonsurgical treatment options for severe obesity and their consequences? What are the surgical treatments and criteria for selection? What are the efficacy and risks of surgical treatments for obesity? What specific recommendations can be made for the treatment of severe obesity? What are the future directions for basic science, clinical research, and epidemiological evaluation of therapy?

The statement includes basic information about the condition known as severe obesity. (The panel believed the more commonly used term, morbid obesity, is pejorative.) Severe obesity is calculated in reference to the body mass index

(BMI). That is, a BMI of 40 kg/m^2 (weight in kilograms divided by height in meters squared) constitutes severe obesity. This is roughly equivalent to 100 pounds overweight for an average adult male. Thus, severe obesity may be defined as a hundred pounds over normal body weight according to the Metropolitan Life Insurance Company tables of 1983 and/or somewhat less than that when accompanied by significant medical illness such as coronary artery disease, hypertensive cardiovascular disease, renal failure, hypoventilation syndrome, diabetes, or joint problems. Someone over fifty kilograms per meter squared—or 225 percent over normal weight—is super morbidly obese. For the specialist, the BMI formula is exact. For the profession as a whole, it is perhaps not as helpful, and many laypersons will not understand it. One hundred pounds over normal weight is much more intelligible to most patients.

No one disputes the benefits of weight loss for the severely

tion of VLCD generally can be avoided or corrected by the inclusion of high-quality protein and frequent physician surveillance. Recent studies show that rapid weight loss may be associated with a substantial incidence of symptomatic gallstones.

The panel endorsed two surgical treatments for severe obesity; vertical banded gastroplasty and the Roux-en-Y gastric bypass operation. Vertical banded gastroplasty is a form of stomach restriction in which a small pouch is made by stapling off a large section of the stomach, creating a narrow, restricted pathway to the intestinal tract. The Roux-en-Y stomach bypass consists of a small pouch created at the upper portion of the stomach to which a Y-shaped section of small bowel is attached to serve as an outlet from the stomach to the intestinal tract.

The two operations were recommended by the panel for patients whose BMI exceeds 40 and who are judged to have a low probability of success with nonsurgical measures. In certain instances, less severely obese patients also may be considered for surgery, such as those with life-threatening cardiopulmonary diseases or severe diabetes mellitus.

Significant weight loss as a result of these procedures usually occurs, and a number of associated disorders often improve. These include sleep apnea, obesity-associated hypoventilation, glucose intolerance, diabetes mellitus, hypertension, and serum lipid abnormalities. Many patients also report improvements in mood and other psychosocial aspects of their lives. Death rates from these procedures are low, but significant complications may occur, including leaks from staple or suture lines, diarrhea, persistent vomiting, ulcers, and gallstones. In addition, some patients fail to lose weight from these procedures and may require reoperation.

The panel emphasized that deficient nutrition in preg-

nancy carries a high risk of fetal damage or loss. Women with reproductive potential are advised to avoid pregnancy until weight has stabilized postoperatively and micronutrient deficiencies have been identified and treated. Secure birth control methods should be provided for patients during the period of weight loss after surgery. Women who become pregnant following these procedures need special attention. The increased nutritional needs and the normal need for weight gain during pregnancy must be emphasized as part of the obstetrical management of these patients.

Patients seeking therapy for the first time should be considered for treatment in a nonsurgical program with integrated components of a dietary regimen, appropriate exercise, and behavioral support and modification. Patients who are candidates for surgery should be selected carefully after evaluation by a multidisciplinary team with medical, surgical, psychiatric, and nutritional expertise. Postoperative care, nutritional counseling, and surveillance should continue for an indefinite period.

Future directions for research include a recommendation that centers be developed that can manage patients with clinically severe obesity, using a multidisciplinary approach. The panel also recommended that these patients be entered into controlled investigations with long-term follow-up. The panel also emphasized the need for well-organized clinical trials that address critical issues surrounding surgical procedures, and better vocabulary and nomenclature to define terms related to obesity.

Single free copies of the complete *NIH Consensus Statement on Gastrointestinal Surgery for Severe Obesity* may be ordered from the Office of Medical Applications of Research, NIH, Building 1, Room 260, 9000 Rockville Pike, Bethesda, MD 20892 (301-496-1143).

obese. Disagreement centers on the modalities to bring it about. Participants in the consensus conference did agree that medical treatment, diet, behavioral therapy, and psychiatric treatment have not proved particularly effective as far as severely obese patients are concerned. The data show that between 96 and 98 percent of nonsurgical modalities fail: the benefits do not last five years. Diets are the most popular treatments. Diet programs have become a several billion dollar industry, but rarely work. The option known as very low caloric diets (VLCDs)—400 to 800 calories a day with increased protein and minimal fat—does achieve significant weight reduction. A loss of 40 pounds over twelve weeks can be expected. But patients normally gain all their weight back within one year, and each time they diet, they gain the weight back faster and overshoot the previous weight. It is thought that all diets cause a lowering of the basal metabolic rate and when persons break the diet, they will process calories in a

more efficient fashion, thereby, regaining the lost weight. People who are severely obese almost always have a low metabolic rate, so that diets are at best a temporary aid.

Other options in vogue for weight loss are behavior modification, exercise, and drugs. "Behavior modification" is on the lips of every physician. However, data presented at the conference demonstrate that behavior modification typically results in a loss of, at best, some 30 or 40 pounds. And, there are no significant data to show that the results are any more lasting than in the case of diets.

Neither is exercise effective. The advocates of exercise therapy admit that it works only if a person does one hour of aerobic exercise a day; for most people that is an unrealistic expectation.

Drugs simply suppress appetite, which returns after the drugs are discontinued. Amphetamines and thyroid medications are simply unsafe.

The surgeons at the consensus conference presented clear data to show that surgical means have achieved significant permanent weight loss, with a mortality rate of less than 1 percent. This is important as the mortality and morbidity rate of severely obese people, especially males, can be as much as twelve times that of the general population.¹

The two most common surgical treatments for severe obesity are vertical banded gastroplasty and gastric bypass. A third, the biliary-pancreatic bypass, is a more radical malabsorptive operation which is more popular in Europe than in the United States. The operations work by restriction of food intake through size reduction of the gastric pouch and/or by malabsorption of nutrients. My personal preference is for the gastric bypass because it results in somewhat better weight loss and is not quite as obstructive as the vertical banded gastroplasty in which a band is placed around the gastric pouch outlet.²

Despite the demonstrated effectiveness of surgery, the panel seems cautious in discussing surgery's application to particular patients. The statement says, "Patients seeking therapy for the first time should be considered for treatment in nonsurgical programs." Those include diet, exercise, and behavior modification. While that course is appropriate for the moderately obese, it will not be efficacious with the severely obese. The panel issues a further caveat about highly motivated patients. "The possibility should not be excluded that the highly motivated patient can achieve sustained weight reduction by a combination of a supervised low-calorie diet and prolonged, intensive behavior modification therapy." The panel, however, offered no data to support that conclusion. In my opinion, as soon as the patient reaches the formulaic number of 100 pounds over desirable weight, the first preferred option should be surgical intervention. Other options have simply failed, as the panel notes in summing up its discussion of these treatments: "Although acceptable weight reduction may be achieved, a major drawback to the nonsurgical approach is failure to maintain reduced body weight in the vast majority of patients."

In the selection of surgical candidates, the first criterion is actual weight. In addition, the panel calls for "a complete medical evaluation by a multidisciplinary team with experience in obesity management." I dispute this stipulation. First of all, I would be hard pressed to find a multidisciplinary team. Even if the surgery were done only at medical centers, there would not be enough bariatric specialists to meet the demand. And, if the specialists were available in sufficient numbers, who would pay for the evaluation? The typical patient cannot afford to do so. Furthermore, physicians do not exact that kind of evaluation in the case of any other disease. As long as the patient is evaluated by a good internist or family practitioner, the multidisciplinary evaluation seems unnecessary unless specific problems indicate the need for other expert opinion.

In practice, surgery for severe obesity is a last resort. By the time patients consult a surgeon, it is already clear that other options are not going to work. It is not realistic to ask them to try alternative therapies in order to certify that they have exhausted all other options. The literature abounds in data showing that the alternatives are unlikely to work. Severe obesity is, as the consensus statement says, "a chronic intractable disorder."

The consensus statement appears to lay down still another stipulation when it asserts that "Gastric restrictive or bypass procedures should only be considered for well-informed and motivated adult patients with acceptable operative risks." If the patients qualify as acceptable operative risks, then, insurance companies argue, they are not really ill. They do not have high blood pressure or diabetes, so the patients must not really need the surgery but must be seeking purely cosmetic benefits. It is a struggle to get insurance companies to recognize severe obesity as *itself* an object of treatment. For instance, I have a 25-year-old patient who weighs 391 pounds. She is being challenged to prove that she is genuinely ill; otherwise, the insurer will not approve her surgery. What does she need to say other than that she weighs 391 pounds? Are we to wait until her bones disintegrate or until she develops cardiovascular disease—in short, becomes truly an operative risk? A patient who needs the operation is, by definition (or will be shortly), already suffering from some of the conditions that make him or her an operative risk. People cannot walk around with these levels of weight without an eventual deterioration of health.

Following surgery, the resulting weight loss generally effects an amelioration of co-morbidity factors such as hypertension, glucose intolerance, sleep apnea, dyslipidemia, and diabetes mellitus. Something like 80 percent of patients with diabetes mellitus improve significantly after weight loss. The same is true of those with high blood pressure, high lipids, joint and back problems, symptomatic varicose veins, hiatal hernia, hemorrhoids, and snoring complaints. Patients also report improvements in mood and other psychosocial aspects.

The incidence of complications from surgery is between 7 and 10 percent. These include staple line disruption, diarrhea, ulcers, gallstones, and vomiting. The appearance of gallstones is a common occurrence following gastric surgery since loss of weight is lithogenic. One of the problems I have seen, since the bile is diverted downstream, is the development of ulcers in about 10 percent of patients.³ So I now make sure that for many weeks after surgery, patients are on an anti-ulcer regimen. (I also had one patient who developed symptoms of hypoglycemia following the surgery. She was found to have an islet cell tumor. The gastric bypass acted in a provocative fashion and produced the symptoms of hypoglycemia; then the condition could be diagnosed. Prior to surgery, she had never had such symptoms. In fact, multiple fasting blood sugars were normal.)

Commentary

Some patients fail to lose weight after surgery. An operation is considered successful if the patient loses 30 percent or more of total body weight; a 25 percent loss is viewed as acceptable. Anything less is defined as a failure. The most common cause of failure is a staple line disruption. Other patients may be grazers; despite the reduction in the size of the gastric pouch, they find ways to ingest large amounts of calories (e.g., drinking high-calorie soft drinks or alcohol). I will be reoperating on a patient whom I initially thought had had a staple line disruption. Prior to surgery he weighed 418 pounds; three years later he is at 390. He has slowly and methodically continued to eat. I assume he eats all day long. I will take the Y-loop of the bypass further downstream to induce greater malabsorption (i.e., I will convert him to a biliary-pancreatic bypass).

Although surgery always aims for perfect results, we have not yet succeeded. We find that, four or five years after the gastric surgery, there is usually a weight gain of 10 to 20 pounds. But it is important to emphasize that our objective is not to make svelte people. Although most patients are still overweight years after surgery, they are immeasurably improved. A layperson might ask if patients continue to lose weight without stopping. They do not. I did, however, have one patient who developed anorexia nervosa. She got down to 155 pounds but decided she would look much better at 105. With appropriate treatment, she recovered. Typically, a patient levels off around twenty to forty pounds over ideal weight.

As the statement indicates, long-term patient follow-up is necessary. Nutritional counseling, surveillance, and postoperative care should continue. After doing these operations about once a month for five years, my own experience is that the operation initiates a lifelong commitment to the patient. It is not a matter of performing the operation and leaving the patient to his or her own devices. Patients must be checked to make sure they do not slip. I also work closely with a nutritionist who monitors the patients and prescribes vitamins and minerals.

Because the radical weight loss following surgery can precipitate major life changes, including changes in personality and in relationships, a support group of some sort should be offered. Changes are, for the most part, positive (e.g., self-image improves tremendously). In the support group, my patients talk about everything from what they can and can not eat, to ways to handle dumping (the osmotic pull of carbohydrate particles causing weakness), to changes in personal appearance, to family and work relationships. The support group often serves as the context for discoveries about the health process. The surgery, for example, has its own built-in behavior modification. Since people who have had the surgery cannot eat very much at any given time, they quickly learn to adapt. They eat more slowly and eat smaller amounts. It is also true that many patients who formerly ate red meat or who drank milk are unable to do so after the

surgery. Every person's experience is unique. As a group, they can talk about emotional experiences, home problems, and conflicts. I remember one patient whose husband was force-feeding her. His first wife had weighed 450 pounds, and he could not accept the fact that his second wife had dropped from 300 to 200 pounds. Group members benefit from talking together or they may be left with problems they can not manage and which may not be addressed or discovered by the physician.

In addressing future directions, the consensus statement speaks of the need for centers that can manage patients with severe obesity in a multidisciplinary approach. That idea is sound, but we cannot rule out other settings; there are too many people suffering from this disease.

I see the *Consensus Statement on Gastrointestinal Surgery for Severe Obesity* as an important step. For the first time we have a clear consensus that gastric surgery is a valid treatment option for severe obesity. I think the panel was generally fair in its assessment. The panelists were not selected for specific expertise in obesity. Rather, they were from a variety of medical fields, and were asked to keep an open mind and to listen to the papers.

I think the statement will steer medical personnel to consider whether patients might benefit earlier from gastric surgery. Gastric operations have been in use since 1968 when Dr. Edward Mason did his first gastric bypass for obesity. Although some physicians may be concerned about the morbidity and the mortality associated with surgery, the morbidity and mortality of someone left in an obese condition can be far worse.

My own involvement in this specialization came about gradually. Intestinal bypass operations seemed parallel to giving someone a gallon of milk of magnesia a day; the surgery was simply causing rapid transit time, and the malabsorption was based on that. But the gastric operation interested me because I grew up at a time when gastric surgery was often used for peptic ulcers. One fact that was quickly noted in the literature was that after a gastrectomy for ulcers, patients invariably lost weight. So when Dr. Mason began to talk about gastric bypasses, my interest was piqued. In addition, the sequelae of those gastric operations were not that serious. They included dumping, which we are able to treat by dietary modification and medication, and malabsorption of B₁₂ and iron.

It seems to me that we need to assess our present position as a profession. Today, most everybody is interested in breast cancer, but interest in severe obesity lags. It is curious to me that laypersons have taken the lead in the management of this condition—creating programs like Nutrisystem, Opti-Fast, and Weight Watchers—while physicians have virtually ignored the whole matter. Many physicians would rather treat its consequences. The prevailing opinion is that obese people have brought the condition on themselves because of their

Commentary

own sloth, and for the most part, that is not true. There *are* compulsive eating disorders. I do not believe that most physicians even think about treating obese patients surgically. Very few physicians really treat obesity at all except to say, "Here's a diet plan. Follow it." I think the condition is looked at somewhat in the same way as alcoholism. "You're an alcoholic. Join AA." That is not going to work.

One outcome of the consensus conference is to signal physicians that we now have an effective modality to treat severe obesity. Unfortunately, an earlier group of operations to treat severe obesity—the intestinal bypass procedures—proved disastrous. A myriad of problems resulted, including diarrhea, renal stones, electrolyte imbalance, decreased bone density, bypass enteritis, and devastating liver disease. So when another group of operations dealing with the stomach emerged, physicians probably dismissed them as well.

The people who suffer from severe obesity are a unique group. They are vilified as a consequence of the way they look. They experience discrimination. Most of the severely obese are women, who have gender-related prejudice to deal with as well as their weight. They are looked upon with considerable disfavor not only by their peers but by physicians as well. Physicians do not like fat people; surgeons as a group do not like them either. Fat people are harder to treat if they have a medical or surgical illness and they are difficult to manage.

The audience at the NIH consensus conference was composed almost entirely of members of the medical profession. But also in the audience were two women from the National Association for the Advancement of Fat Americans (NAAFA). One weighed 350 pounds and the other almost 500 pounds. They objected vigorously to the conference altogether. Being fat, they insisted, is okay; they did not need our help, either medical or surgical. They drew a lot of fire from the audience. Later I spoke to one of them, the president of the association. I tried to explain that they were at a medical conference, and that physicians do disagree among themselves without being confrontative. "We're really on your side," I said. "We're trying to save your lives." She looked at me and smiled.

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WILLIAM Y. MARCUS, M.D.

Dr. Marcus is a general surgeon in private practice in Silver Spring, MD and a clinical instructor in surgery, George Washington University Medical School. ■

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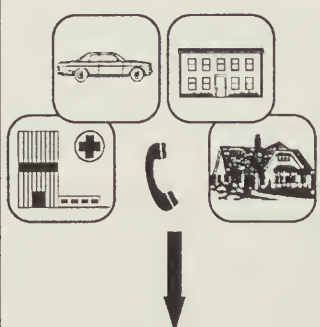
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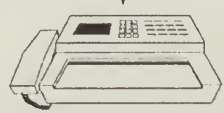
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A Clinical Moment with . . . Diabetes

Gestational diabetes mellitus

Doctor, I have been a physician for forty years. Today I received a letter from my daughter who is pregnant. Her doctor told her she has developed diabetes. Neither I nor my wife have diabetes. Can pregnancy cause diabetes?

Less than 1 percent to more than 20 percent of women develop an impaired glucose tolerance (IGT) during pregnancy. In fact, pregnancy is normally accompanied by a mild degree of glucose intolerance and occasional glucosuria. Impaired glucose tolerance discovered during pregnancy is termed gestational diabetes mellitus (GDM). A known insulin-dependent diabetic patient (IDDM) who becomes pregnant is not classified as having gestational diabetes.

All pregnant patients should be screened for diabetes mellitus. It is most likely to be found in obese women, in those with glucosuria, and in those with a family history of the disease. A good procedure is to screen for diabetes at the first visit, at the twenty-fourth to twenty-eighth week of gestation, at the thirty-second week, and at any other time that signs or symptoms of the disease occur. If glucose intolerance occurs before the twentieth week, it probably represents an asymptomatic abnormality in carbohydrate metabolism that antedated the pregnancy.

Screening for diabetes during pregnancy can be done by one of the following methods:

1. Fifty g. of glucose load given at random with a one-hour post-load plasma glucose test. The cutoff point for positivity is equal to or greater than 130 mg/dl.
2. A 75 g. glucose load given at random with a two-hour fingerstick test. The cutoff point for positivity is equal to or greater than 120 mg/dl.
3. A 100 g. glucose load given fasting with a two-hour plasma glucose test. The cutoff point for positivity is 140 mg/dl.

If the screening test is positive and a follow-up plasma glucose test is confirmatory, a glucose tolerance test is not necessary and would be considered a risk to the patient. If in doubt after doing a screening procedure, the standard glucose tolerance test for gestational diabetes is done as follows:

1. The test is performed in the morning after an overnight fast of eight to fourteen hours and at least three days of unrestricted diet (greater than 150 g. of cholesterol intake per day).
2. There is unrestricted physical activity prior to the test.
3. A 100 g. oral glucose load is given in a volume of at least 400 ml of fluid.
4. Venous plasma glucose amounts are measured fasting and at one, two, and three hours (Table).

Table. Diagnostic criteria for gestational diabetes from the National Diabetes Data Group

Fasting	105 mg/dl.
1 hour	190 mg/dl.
2 hour	165 mg/dl.
3 hour	145 mg/dl.

Two or more values must be met or exceeded to be confirmatory of diabetes mellitus.

Treatment is the adjustment of the meal plan, if indicated, and increased exercise. While controversial, most authorities believe that caloric restriction in obese pregnant women is contraindicated. If dietary management does not maintain the fasting plasma glucose at or less than 105 mg/dl and/or the two-hour postprandial plasma glucose at 120 mg/dl or less within a two-week interval, insulin therapy should be initiated. Biosynthetic human regular insulin should be used in one or more doses daily. Many of these patients are excellent candidates for insulin pump-type therapy. Sulfonylurea drugs do not have the Food and Drug Administration (FDA) approval for use during pregnancy.

Postpartum, these patients

- May revert to normal. Previously abnormal glucose tolerance (Prev AGT)
- May remain impaired. IGT
- May have persistent diabetes. IDDM

Thirty to 40 percent of gestational diabetes mellitus patients will develop diabetes within five to ten years after parturition and should be followed closely. Prevention of future pregnancies and strict weight control might be deterrents in the development of IDDM.

The newborn infant should usually be managed in the intensive care unit of the nursery.

DEWITT E. DELAWTER, M.D.
Editor

STATE OF THE ART



DIAGNOSTIC TECHNOLOGY

Magnetic resonance imaging (MRI) is an important tool for today's physician. MRI produces VIVID images of the body in multiple planes. It is a painless procedure that does not involve surgery or potentially harmful radiation. MRI is frequently recommended for evaluation of neural, spinal, articular and pelvic disorders. It is safe and cost effective, and its various applications are being expanded at an impressive rate.

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Imaging Case of the Month

A middle-aged African-American female presented to the neurology service due to increasing severity of headaches. The patient complained of decreased sensation in her hands. Results of physical examination demonstrated atrophy of the fine motor muscles of her hands, as well as scars and burns on her fingers. The patient had decreased pain and temperature sensation in her arms and hands, with preserved pain and temperature sensation in the lower extremities. Due to the constellation of signs and symptoms, a magnetic resonance imaging (MRI) examination of the skull base and cervical spine was performed (Figures 1 and 2).

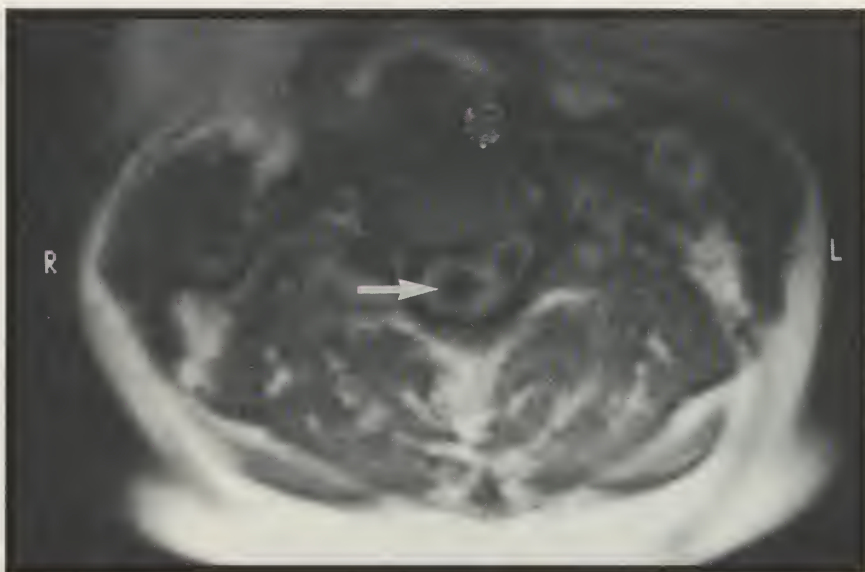


Figure 2.



Figure 1.

Imaging Case of the Month

Imaging Case of the Month is a new department of the *Maryland Medical Journal* which will be featured on a regular basis. Coordinated by the Maryland Radiological Society, the cases will review a broad range of diseases and pathological processes of interest to a wide range of specialists. Physicians interested in submitting cases for publication consideration should contact the Department Editor.

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Arnold-Chiari I malformation with syringomyelia

Figure 1. Sagittal T1 weighted MRI scan of posterior fossa, brain stem, and cervical cord demonstrates downward displacement of the cerebellar tonsils (curved arrow) and a large syrinx cavity commencing in the upper cervical spine and continuing inferiorly into the thoracic spine (straight arrow).

Figure 2. Axial T1 weighted MRI image demonstrates the large low signal syrinx cavity within the center of the cervical cord (arrow).

Discussion

This patient presents with the classic signs and symptoms as well as radiologic findings of the Arnold-Chiari I malformation. Arnold-Chiari I malformation is defined as the downward prolongation of the cerebellar tonsils posterior and posterolateral to the cervical spine cord, usually to the level of C1 and sometimes as low as the C2 or C3 level.¹ A Chiari I malformation will have tonsillar herniation ranging from 3 mm to several centimeters below the posterior margin of the foramen magnum.² The cerebellar tonsils often assume a peg-like configuration. As opposed to the Chiari II malformation, there is no caudal displacement of the medulla or inferior vermis of the cerebellum in Chiari I malformation. The fourth ventricle usually maintains a normal position, though it may be distorted in shape.

Chiari I malformation is associated with syringomyelia in up to 80 percent of patients.³ In Arnold-Chiari I patients, there is often arachnoidal scarring and adhesions in the region of the cisterna magna causing matting of the tonsils, vermis, cord, and medulla. The degree of adherence may be related to the likelihood of developing syringomyelia, by causing the thrust of cerebrospinal fluid pulsations to be directed into the central canal of the cord.⁴ The signs and symptoms in this malformation are related to the compression of the spinal cord

or cerebellum, or to the syringomyelia. The onset of symptoms is usually delayed until adulthood.⁵

Associated findings in Arnold-Chiari I malformation include the aforementioned high incidence of syringomyelia, basilar invagination in 25–50 percent, and increased incidence of atlanto-occipital and atlantoaxial fusions. Other skull base malformations and cervical spine malformations (such as Klippel-Feil syndrome) may occur.^{1–5} The cisterna magna in these patients is often small. Hydrocephalus may be seen in up to 44 percent.⁵

MRI is the single best imaging technique for the evaluation of Chiari malformation due to its ability to image structures in multiple planes; ability to image the brain, spinal cord, and cerebrospinal fluid spaces without the use of intrathecal contrast; and the lack of bone scatter artifact at the skull base.

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EDGAR FEARNOW, M.D.
Department Editor



PHYSICIAN'S RECOGNITION AWARD

During January 1992, the physicians listed below received the American Medical Association's (AMA's) Physician's Recognition Award. Established in 1968, the Award's purpose is to encourage physician participation in continuing medical education and to recognize those physicians who have voluntarily completed programs of continuing medical education.

Albert, Hubert Joseph
Billingsley, Frank Sidney
Cockburn, Manuel S.
Cohen, Sidney Joseph
Collis, Peter Buckley

Davick, Alan Marc
Diaz Avila, Mario H.
Domenick, Mark Thomas
Funk, Edwin H.
Huang, Edwin Kirk

Johnson, Donald Robert
Katz, Ronald Alan
Kletz, Michael Robert
Miller, Louis Winaker
Niklewski, Edmund Victor

Pearson, Frederick Norman
Rappeport, Jonas R.
Renjel, Luis E.
Snow, Paul

Censors of Maryland

One of the small thrills of answering a reference question in the Faculty archives is coming across something of interest that has little or no bearing on what you were actually seeking. This happened to me recently while trying to track down some material on nineteenth century medical prizes. Digging through one of the many unsorted storage boxes in the Faculty basement, this one marked "nineteenth century," I discovered half a dozen records and reports from the early Medical Board of Examiners and Censors, which was operated by the Faculty.

As the examination and licensing of physicians was one of the primary reasons (though by no means the only one) for which the Medical and Chirurgical Faculty was founded, coming across these records was more than just a pleasant surprise. Though they are mentioned in several places in Cordell's *Medical Annals*, actually having access to them could provide more primary information about the Faculty's first several decades than we currently possess.

The history of medical licensing in colonial America is a long one, rife with accusations and countercharges from those involved on both sides of the issue. In fact, to cover all aspects of the issue would require more space than the *Maryland Medical Journal* provides, so the following is only a capsule summary. The goal of the Medical and Chirurgical Faculty as regards licensing was succinctly summed up by President John Quinan in 1886 in his presidential address on the history of the Faculty at the annual meeting for that year:

The promotion and dissemination of medical and chirurgical knowledge throughout the state...and prevention of its citizens from risking their lives in the hands of ignorant practitioners or pretenders of the healing art. The Faculty granted, via the Medical Board of Examiners, power to grant licenses to such medical and chirurgical gentlemen as they, either upon full examination, or upon the production of diplomas from some respectable college, may judge adequate.¹

Though initially granted far-reaching powers of review over physicians in the state, the force of the law was increasingly diluted by the Maryland state legislature, causing the Faculty license to lose any semblance of regulatory status. This dilution of the law can be seen readily in the broad interpretation in 1838 of a decision that allowed Thomsonians² to charge fees for services. After addressing the specific issue of the Thomsonians, the act went on to allow "any citizen of Maryland to charge or receive fees for medical services as physicians as are now permitted to do." This, in effect, allowed any persons who wished to claim they were doctors to do so and to charge the appropriate fees.³

This is exactly what did occur in Maryland as a result of this law and similar laws around the country. Though widespread, the phenomenon was hardly new. William Smith, writing of New York in 1758, claimed that "quacks abound like locusts in Egypt, and too many have recommended

themselves to a full and profitable practice and subsistence."⁴ The situation in the new world due to the lack of standards, both before and after the American Revolution, was ripe for encouraging both quacks (**Figure**) and true physicians. Also, as was pointed out in the Faculty's sesquicentennial history, the low expectations of the public were as much at fault as the lack of standards: "the easy entrance of charlatans into a practice that sometimes proved lucrative was furthered by a high degree of credulity in the public."⁵

By the latter part of the eighteenth century and the start of the nineteenth, the country was practically swamped with medical personnel. It was common knowledge among both those already established in the United States and recent emigrants, that many of these exparte physicians were not exactly the cream of the crop of the European medical community. After all, what educated physician would willingly give up the social position, limited as it was, that even a moderately successful practice in Europe would provide, for the uncertainties of the new world? Consequently, even those physicians who had degrees from a medical school were not fully trusted by the general public. One frontier family wrote that "doctors were suspect...to be sent for only as a last resort...sick people did get well sooner or later, if they didn't die."⁶

In addition, common folk were more likely to turn first to a nontraditional practitioner (Thomsonian, Botanic, and the like) before an educated physician, whether the physician was a recent emigrant or a native-born and trained American. William Lindsey writes in his medical journal of a young girl who suffered a fractured arm as a result of being run over by a carriage. Yet, it was a "steam doctor" who was contacted first. It was only after this pretender announced that the arm was not fractured and he remained unable to effect a cure that he was dismissed, and the licensed Dr. Lindsey was called in.⁷



Figure. An example of one of the early American "home remedies" is the Perkin's Tractor developed in the 1780s by Elisha Perkins (1740–1799). A popular maker of home remedies, Perkins has long been regarded as one of America's earliest medical quacks. The claim that Perkins made for his metal tractors was that by drawing the point of the tool across an injury or pain, it would draw out any harmful forces and facilitate healing. The tractors were widely popular for a brief period of time.

The feelings of mistrust were common throughout Maryland, and Medical and Chirurgical Faculty members were acutely aware of it. Men like George Brown, John B. Davidge, and James Steuart knew that it was not enough for the Faculty to license qualified physicians who were willing to submit to the Faculty's examinations; those who were not qualified and licensed had to be sought out and their faults brought to light. "In the three years (1799–1803) of the existence of the [Faculty], there had been frequent violations of the law"⁸ — exposing fraud would be the only way the public could be expected to trust someone who claimed to be a physician. Thus, the censors came into play.

The censors in Maryland were often young physicians who, according to the Faculty, displayed the qualities necessary to be responsible members of the medical profession. One of these young men was D.M. Reese. Born in Maryland in 1800, Reese received his medical degree in 1819 from the University of Maryland and accepted positions as both censor for the third ward of Baltimore and as one of several vaccine physicians for the city in 1824. From 1841 to 1842, he served as professor of medicine at Castleton College in Vermont. Reese returned to the Baltimore area in 1842 as professor of the Institutes of Medicine and Medical Jurisprudence at the Washington University. A physician dedicated to the advancement of his profession, Reese was also one of the founders of the New York Academy of Medicine, served as vice-president of the American Medical Association (1857), and helped to edit both *Cooper's Dictionary of Practical Surgery* and the *American Medical Gazette*.

The following letter was written by Reese in 1824 to then President George Frick regarding an *Indian Doctor*. The title of *Indian Doctor* is interesting when one considers the low esteem in which Native Americans were held by most white settlers in the 1800s. The sesquicentennial of the Faculty offers the added insight that "men and women who were properly scornful of the primitive attainments of the Indian in the practical arts had, nevertheless, great faith in any nostrum described as an Indian remedy."⁷

June 5, 1824

Sir,

The censor of the Medical and Chirurgical Faculty of Maryland for the third ward, city of Baltimore, would respectfully represent

That Dr. Job Smith, the *Indian Doctor*, whose prosecution was entrusted to him at the last convention, and in which case a committee was appointed to assist in inflicting the penalties of the law, has left the city on being notified of the intention of the Faculty toward him. Of course, the committees were not required to pay attention to his case.

He has been succeeded, however, by another self-styled *Indian Doctor*, whose obscurity would seem to render it unnecessary to take notice of him, were it not my duty in making this report to mention all unauthorized practitioners in my district.

The members of this Faculty are generally informed that a man styling himself Doct. A. Martin, has been dealing in the "work of death" very extensively in this city during the last few months, by the use of the medicines of M. Le Roy. The

repository of the specific of this very popular quack is in the third ward from which he deals out his drugs "of which he knows less" with great diligence and success, at least a pecuniary point of light. When, however, a number of professional gentlemen complained to me of being greatly annoyed by his interference and a number of his patients, having received the wages of their folly and credulity, urged the propriety of punishing this pretender, I took no official notice of him whatever. But these complaints being louder and more numerous, I thought proper to address him a note, acquainting him with the law of the state, his liability to punishment, and my duty towards him; at the same time offering him any facilities in my power by introducing him to the Board of Examiners should he be willing to appear before them.

The result of this communication was an immediate interview, in which he at first attempted to show that he was not amenable to the law having sold only the specifics of M. Le Roy, but finding that I possessed evidence to convict him of having received fees in advance of curing persons, upon whom the grave had closed already in many instances; he desired to be unmolested for one month longer, that he may, as he expresses it, "get rid of his supply of specifics" and assured me that in five or six weeks at most he will leave the city and never again subject himself to the law of this state....⁸

All of which is respectfully submitted,

D.W. Reese,
Censor of third ward
City of Baltimore

One wonders what actually became of Doct. A. Martin, the *Indian Doctor*. Did he get his one month reprieve or not? A search of the city directory at the Enoch Pratt Free Library for that year does not reveal any trace of the good doctor, so we may never know for sure what the results of Reese's efforts may have been. One thing we do know is that even with committed doctors like Reese on the Faculty's side, it would be almost another half century before the force of law was again fully on the side of the medical community. This occurred as a result, according to Paul Starr, of a growing change in the approach toward medical education taken in the United States, as well as the Supreme Court decision in *Dent v West Virginia* in 1881.⁹

Today, we can look to such programs as the Faculty's peer review program and the state's Board of Physician Quality Assurance to protect the public when dealing with the medical community. But it is to men like Dr. Reese, censor of the third ward, and his colleagues that we owe our thanks for making it all possible.

Notes

1. Quinan, John. Transactions of the Medical and Chirurgical Faculty of Maryland. Baltimore: s.n., 1886; 67–68.
2. Starr, Paul. The Social Transformation of American Medicine. New York: Basic Books, Inc. 1982; 52–57. The Thomsonians were the medical community's first organized competition. Founded in 1800, the group took its name from its founder, Samuel Thomson. Thomson's basic premise was that all disease was caused by an imbalance in the body's temperature. The cause was cold while the cure was heat. Heat was best restored, according to the Thomsonians practice, by the use of an extremely dangerous emetic known as Indian Tobacco. Politically and

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socially active, the Thomsonians rapidly gained adherents throughout the first several decades of the nineteenth century in both cities and frontier settlements. Eventually, the group members split among themselves over the issues of required medical education and self-regulation, with those in favor of these two improvements soon becoming accepted by the educated, traditional medical community, while those opposed fell by the way-side.

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The editorial board of the *Maryland Medical Journal* would like to express its appreciation to William Sleeman for his contributions to the *MMJ* over the years, and for his commitment and dedication to enhancing the Faculty's archives, both as a past Med Chi employee and a volunteer.



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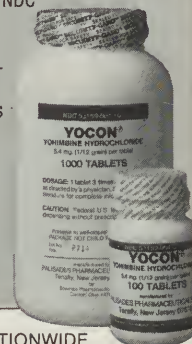
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AMA and the Auxiliary join forces against violence

When 13-year-old Jason came home late Friday night and found his 16-year-old sister Sara and her friends in his room, he pulled out a gun and shot her. Three bullets tore through her face and chest. She died within hours.

Situations like this are not unusual. Last year alone, more than one hundred thousand children faced a brother or sister with a gun or knife in hand, and more than twelve hundred children were murdered by parents, siblings, or other relatives. As shocking as the statistics are, they reflect only a small portion of the population affected by the violence epidemic.

Termed the disease of the 90s, violence is as complex and life-threatening as any of the killer diseases of the past two centuries. It touches as many as one-fourth of all American households, and it often happens between people who know each other—friends, parents, children, and husbands and wives.

According to a recent article in the *Journal of the American Medical Association*, family violence is the single largest cause of injury to women in the United States, more common in fact than automobile accidents, muggings, and rapes combined. As many as 35 percent of women who visit hospital emergency rooms are there for symptoms related to ongoing abuse, yet less than 5 percent of the victims of family violence are identified as such. Conservative estimates put the annual medical costs of family violence at \$44 million—the equivalent of almost one hundred thousand days of hospitalizations, almost thirty thousand emergency department visits, and almost forty thousand visits to a physician each year.

"The prevalence of violence and its consequences on society make it an issue every American should address," says Marshall Rosman, Ph.D., director of the AMA's Department of Mental Health, "particularly those in the medical community, since family violence is a pressing health issue."

To promote medical community involvement in the violence problem, the American Medical Association has launched a nationwide effort to involve physicians in preventing violence and providing help for the victims of child physical and sexual abuse, elder abuse, and spouse abuse. As part of the initiative, the AMA will invite physicians to join the National Coalition of Physicians Against Violence and to work with other concerned groups and individuals to develop

local family violence prevention committees that can set agendas to combat the problem.

Key to the effort will be the AMA Auxiliary. "As physicians around the country join the coalition, we will encourage them to hook up with an auxiliary member in their community," explains Dr. Rosman, coordinator of the national coalition. "Then physicians and auxiliaries can approach state medical societies together to urge them to address the problem and to establish local violence prevention committees."

Local communities will be asked to set an agenda for family violence activities in their communities, which might include such projects as developing a resource book for physicians outlining the organizations and agencies available to aid victims of abuse, or distributing guidelines on child physical and sexual abuse, domestic violence, and elder abuse to physicians and other interested community members.

In addition to aiding the AMA in its activities, the AMA Auxiliary has developed its own program to address the violence problem. Kicked off by 1991–92 AMA Auxiliary President Sherry S. Strebel, the Campaign Against Family Violence encourages state and county medical auxiliaries to develop programs and projects to educate the public about the violence problem and to support the victims of family violence. Auxiliaries are also being urged to work with the AMA to provide physicians with resources.

Several auxiliaries across the country are already addressing the violence problem through such activities as self-esteem and victimization workshops for children and teens; parenting workshops for potentially abusive mothers and fathers; shelters for abused and neglected children and battered women; support groups for violence victims; and crisis centers and hotlines.

"The tragedy of family violence is as much a challenge to the general health and welfare of the nation as it is to the system of justice and law," says Ms. Strebel. "I congratulate those auxiliaries that are already addressing the problem and I urge others to make the commitment and get involved." ■

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MARYLAND

The Auxiliary always welcomes new members.

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For information on becoming a member, call JoAnn Troisi at Med Chi's Auxiliary office.
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Cancer prevention

The carcinogenic process proceeds through multiple stages, namely, initiation, promotion, and progression. Such a process may occupy the major part of an individual's lifetime. Initiation may only require a single exposure to a carcinogen that results in deoxyribonucleic acid (DNA) damage. Promotion involves multiple exposures to agents that do not damage DNA directly, but can do so in multiple phases. Progression is the conversion of a benign tumor to a malignant one. Furthermore, progression can be an open-ended process, since growing tumors often continue to increase in their degree of malignancy and heterogeneity.

Tumor promoters do not bind to DNA, but bind to cell membrane receptors that activate key regulatory pathways producing a cascade of events. These events include alterations in the function of membrane-associated ion channel receptors and gene expression that will result in changes in cellular differentiation and proliferation. With such an understanding of initiation and promotion, scientists have begun to look at specific inhibitors or modulators of the cellular regulatory pathways. In the meantime, clinicians and public health professionals need to apply what is known and feasible to the primary prevention of cancer.

Chemoprevention

Chemoprevention is one means of cancer control. The occurrence of the disease can be prevented by the administration of a chemical or biological substance. A fair number of the compounds that can prevent cancer have been demonstrated in the laboratory. These compounds belong to a wide variety of chemical classes having a great diversity of action. Although this might seem to indicate that a variety of approaches can be used for cancer prevention, there are two basic mechanisms by which chemical agents inhibit carcinogenesis: (1) the agent may alter the manner in which the carcinogenesis occurs in the organism prior to exposure or reaction of target cells to carcinogens, and (2) the agent acts later in the cancer cycle by altering the biological properties of cells that already have been subjected to the effects of chemical carcinogens. Examples of such agents with known chemoprevention activity and proposed mechanisms include (1) vitamins C and E, which block the formation and absorption of carcinogenic nitrosamines in the gastrointestinal tract; (2) beta-carotene and vitamin E, which are effective in trapping free radical carcinogens; (3) vitamin A (retinoids) which suppresses the effect of polypeptide hormones that are produced by tumors and are enhancers of cell division; (4) butylated hydroxyanisole (BHA), which induces a number of liver enzymes that catalyze the conjugation of carcinogens, thus increasing carcinogen solubility and excretion in the urine; (5) disulfiram, which decreases liver microsomal cytochrome P450 oxidase activity for conversion of benzopyrene

in cigarette smoke to its active carcinogenic electrophilic form, which binds and distorts DNA.

There are several problems in designing and implementing a human clinical trial to evaluate the effectiveness of a given chemopreventive agent. First, it is important to study the safety and dose of such an agent. For most of the naturally occurring agents, the dose effect may not be known. The side effects and toxicity in healthy individuals must be able to be tolerated, and must be minor enough to allow the study to continue for years or even for a lifetime. Second, once the agent and dose are determined, the selection of a suitable population depends on identification of the high-risk group. Issues to consider in population selection include the stage of carcinogen the agent is expected to inhibit; the specific cancer being studied; the age-specific incidence; and an adequate population size to allow for a sufficient number of subjects to complete the study, thus being able to calculate occurrence rates. It is important that a chemoprevention trial obtain complete follow-up on all participants and maintain a high compliance rate.

Cancer prevention and antiviral therapy

There is an important association between both ribonucleic acid (RNA) retroviruses and DNA viruses, and human cancer. The best example is the association of hepatitis virus and hepatocellular carcinoma (hepatoma). There is now substantial evidence that long and persistent infection with hepatitis B is associated with a high frequency of development of hepatoma in these individuals. Therefore, prevention of hepatitis infection would probably reduce the incidence of hepatoma. The prevention program is based on the use of hepatitis B vaccine. Such vaccine is recommended for populations at high risk (e.g., health care workers, military personnel, drug addicts, male homosexuals, and newborns of carrier mothers).

Other controls

The use of cigarettes, cigars, pipes, chewing tobacco, and snuff is a well-known cause of lung and oropharyngeal cancer. Tobacco use accounts for 30 percent of potentially preventable cancer deaths. The carcinogenic action of tobacco is enhanced synergistically by exposure to other carcinogens or co-carcinogenic substances. Consumption of large amounts of alcohol and concurrent cigarette smoking substantially increase the risk of cancers of the mouth, larynx, and esophagus. Similarly, individuals who smoke and are exposed to asbestos are four to five times more likely to develop lung malignancies than smokers only, and fifty times more likely than individuals not exposed to either agent.

It is estimated that another 30 percent of cancers may be attributed to diet. Extensive fat intake, inadequate dietary

fiber, and low consumption of micronutrients (trace minerals and vitamins) may be associated with high cancer rates of the gastrointestinal tract, as well as the breast, prostate, ovaries, and endometrium.

Occupational exposure to carcinogens is estimated to be responsible for 4-6 percent of cancer deaths in industrial countries (entire population). However, this figure rises to 30 percent for workers in industrial parks and plants. There are recent indications that the interaction of environmental carcinogens with critical cellular constituents may reflect on genetic damage at the level of the DNA or the chromosome.¹

The National Cancer Institute has established cancer control objectives to reduce the US cancer mortality rate by 50 percent by the end of this century. Scientists who have worked on these objectives believe that this reduction can be achieved if cancer control is fully applied on all levels and by all concerned institutions, organizations, and individuals. The following elements of cancer control will lead to this reduction: (1) primary prevention through smoking control, dietary changes, and reduction in occupational exposure to

carcinogens; (2) secondary prevention through screening and early detection, particularly in the areas of cancers of the breast, cervix uterus, and colon; and (3) improved provisions for and the use of state-of-the-art treatment modalities.

References

1. Engstrom PF. Cancer Prevention. In: Moossa AR, Schimpff SC, Robson MC, eds. Comprehensive Textbook of Oncology. Second edition. Baltimore: William & Wilkins. 1991; 178-87.

E. GEORGE ELIAS, M.D., PH.D.
Professor of Surgery and Oncology
Director, Surgical Oncology Program
University of Maryland

Tumor conferences are held weekly on Tuesday between 8 and 9 a.m. in Room NBW74 at the University of Maryland Medical System. Physicians are welcome to attend this open meeting and to present cases and pathology slides. Call 410-328-5224 by noon Monday to be placed on the schedule. Surgical Oncology Program, University of Maryland Medical System, Room N13E02, Baltimore, Maryland 21201. ■



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Board of Physician Quality Assurance Actions

In the matter of
Mohammed H. Amirgholi, M.D.
before the
Maryland Board of
Physician Quality Assurance

Denial of petition for reinstatement

By final decision dated February 5, 1990, the Board of Physician Quality Assurance (the board) voted to revoke the license of Mohammed Hussein Amirgholi, M.D. (the respondent).

The final decision contained no time period or conditions for petitioning the board for reinstatement of his license. COMAR 10.31.01.12.C states

When an order of revocation or suspension states a time for reinstatement of a license, the accused shall make written request for reinstatement to the commission at the expiration of the stated time. When a time period is not stated on the order, a petition for reinstatement may not be entertained before the expiration of one year after the date of the order.

The board's final decision stated no time period at which the board would consider a petition for reinstatement. Therefore, respondent could not petition for reinstatement of his license prior to February 6, 1991. However, since the time that respondent's license was revoked, respondent sought guidance from the board as to what he could do in order for the board to consider reinstating his license. Therefore, the board, through its settlement conference (the conference), met with respondent and his attorney on Wednesday, December 5, 1990. The settlement conference made recommendations to the board as to what respondent must accomplish in order for the board to consider reinstating his license when respondent is permitted to petition the board.

At its meeting on December 12, 1990, the board considered the settlement conference's recommendation and voted to amend its final decision. The board issued the amended final decision on December 26, 1990. As part of the amended final decision, the board stated that prior to applying for reinstatement, respondent must submit evidence that he had complied with four conditions.

Respondent attempted to apply for reinstatement having informed staff that he had evidence that he had complied with the four conditions precedent for application for reinstatement. The conference met on April 24, 1991 to consider respondent's request. Upon consideration of the information given at the conference and the information submitted to the board, the conference issues the following denial of respondent's petition.

Findings of fact

1. The findings of fact of the board's final decision dated February 5, 1990 are incorporated by reference.
2. The findings of fact of the board's amended final decision of December 26, 1990 are incorporated by reference.

3. The amended final decision contained provisions with which respondent was obliged to comply as conditions precedent to the board's considering reinstating his license with conditions to practice medicine. Specifically
 - a. Respondent has continued in therapy on a regular basis with his therapist. Respondent's therapist must submit a report to the board indicating the progress respondent is making and the number of times respondent sees his therapist from December 5, 1990 to the time of the petition for reinstatement. Respondent must sign a release permitting the therapist to report to the board;
 - b. Respondent has completed all continuing education requirements for three years preceding the time of the petition for reinstatement, such requirements being fifty credits for each year;
 - c. Respondent has continued working in the Washington Free Clinic and the director has submitted a report indicating the nature of respondent's duties and the time respondent gives weekly to the clinic from December 5, 1990 to the time of the petition for reinstatement; and
 - d. Respondent has been evaluated by Edward J. Kowalewski, M.D., professor emeritus, School of Medicine, University of Maryland at Baltimore, Department of Family Medicine (the evaluator). The evaluation would cover an overview of respondent's practice and focus upon respondent's knowledge and practice of otolaryngology. Respondent would bear the expense of this evaluation and must sign releases permitting the board to give the evaluator information to assist in the evaluation, permitting the board to inform the evaluator of the final resolution of this matter, and permitting the evaluator to forward his report to the board. Respondent must comply with all reasonable requests of the evaluator.
4. As to condition 3a the conference found that
 - a. Prior to the conference, respondent had not submitted a report from his therapist.
 - b. At the conference, respondent submitted a letter from his therapist dated April 22, 1991, which did not state the number of times, exactly, that respondent had seen his therapist from December 5, 1990. The report stated that respondent had appointments twice a month. However, the report from the evaluator dated March 15, 1991, indicated on page 3 that respondent had decided to stop his psychiatric therapy.
5. As to condition 3b, the conference found that respondent has complied with condition 3b and completed the continuing education requirements by attending the Johns Hopkins Medical Institutions Grand Rounds and regularly scheduled medical conferences, academic year 1990-1991, and receiving fifty-six AMA Category 1 credit hours.
6. As to condition 3c, the conference found that
 - a. The board received a report dated April 15, 1991, from the medical program director of the Washington Free Clinic which stated that "[Respondent] has served as a volunteer physician at the Washington Free Clinic since April of 1989. We have been very pleased with his dedication and his work. We highly recommend him as a candidate for licensure."
 - b. This letter indicated that respondent had continued working in the Washington Free Clinic;

Board of Physician Quality Assurance Actions

- c. The letter did not indicate the nature of respondent's duties; and
 - d. The letter did not indicate the time respondent gives weekly to the clinic.
7. As to condition 3d, the conference finds that
- a. Respondent has been evaluated by the evaluator. On February 18, 1991, the evaluator and three other physicians met with respondent to perform an evaluation focusing upon respondent's knowledge of otolaryngology. The board received the report on March 27, 1991.
 - b. The goals of the evaluation group were to determine
 - (1) What kind of medicine respondent intended to practice, if his license were reinstated;
 - (2) Respondent's specific knowledge regarding the practice of otolaryngology and allergy;
 - (3) If respondent has increased his knowledge base through continuing medical education since 1984;
 - (4) Respondent's capabilities in an office practice, including management, medical records, attitudes, and behavior, according to today's standards; and
 - (5) If respondent is safe to practice medicine.
 - c. The evaluation group found, *inter alia*, that
 - (1) Respondent does not possess adequate medical knowledge or clinical decision-making skills to allow him to safely practice medicine;
 - (2) Respondent's efforts to pursue remedial education have been inadequate;
 - (3) Respondent lacks the potential for correcting his deficiencies by remedial education; and
 - (4) Respondent should repeat a postgraduate medical residency training program.

Conclusions of law

The board incorporates by reference the conclusions of law contained in its final decision of February 5, 1990 and its amended final decision of December 26, 1990 and further concludes that respondent DID NOT MEET THE CONDITIONS PRECEDENT FOR APPLYING FOR REINSTATEMENT as follows:

- 1. Respondent did not comply with the intent of condition 3a;
- 2. Respondent did not comply with condition 3c; and

CONCLUDED that respondent's license remains REVOKED and that the Board of Physician Quality Assurance's amended final decision of December 26, 1990 remains in effect.

Order

By the settlement conference and ratification of the chairperson of the board, it is hereby this 25th day of September 1991

ORDERED, that respondent's petition for reinstatement of his license is DENIED; and be it further

ORDERED, that the board will not consider respondent's petition for reinstatement of his license until such time as respondent submits evidence in writing with his petition that he complied with the board's amended final decision of December 26, 1990; and be it further

ORDERED, that the board's amended final decision of December 26, 1990, to which respondent agreed and consented, remains in full force and effect; and be it further

ORDERED, that respondent must remediate the deficiencies noted in the evaluation report dated March 15, 1991 and as set forth in the board's amended final decision; and be it further

ORDERED, that this order is considered a public document pursuant to *Md. State Gov't Code Ann.*, §§10-611, *et seq.*

ISRAEL H. WEINER MD, Chairperson
Maryland Board of Physician Quality Assurance

■ ■ ■

**In the matter of
Peter J. Krokidas, M.D.
before the
Maryland Board of
Physician Quality Assurance
Final order**

Based on information received by the Board of Physician Quality Assurance of the state of Maryland (the board), the board charged Peter J. Krokidas, M.D. (respondent) under the Maryland Medical Practice Act (the act), *MD Health Occ. Code Ann. Section 14-401 et seq.*

The pertinent provisions of the act are as follows:

Section 14-404 Denials, reprimands, probations, suspensions and revocations — Grounds.

(a) *In general.* — Subject to the hearing provisions of section 14-405 of this subtitle, the board, on the affirmative vote of a majority of its full authorized membership, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee

(21) Is disciplined by a licensing or disciplinary authority or convicted or disciplined by a court of any state or country or disciplined by any branch of the United States uniformed services or the Veterans' Administration for an act that would be grounds for disciplinary action under this section;

The grounds underlying the charges of this section are that respondent

- (1) Fraudulently or deceptively obtains or attempts to obtain a license for the applicant or licensee or for another;
- (3) Is guilty of immoral or unprofessional conduct in the practice of medicine;
- (4) Is professionally, physically, or mentally incompetent; and
- (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this state.

The board notified respondent that if respondent did not request a hearing, the board would issue this final order.

Board of Physician Quality Assurance Actions

Based on clear and convincing evidence, the board, on the affirmative vote of a majority of its full authorized membership considering this case, issues this final order.

Findings of Fact

A. The board finds as follow:

1. At all times relevant to these charges, the respondent was and is licensed to practice medicine in the state of Maryland;
2. The respondent was notified by the board on July 16, 1991 of charges filed against him and that the board could sanction respondent as a result of these charges;
3. The respondent was informed that this final order would be executed thirty days from the respondent's receipt of the board's notification, unless respondent requested a hearing;
4. Respondent received the board's charges and notice of intent to sanction under the Maryland Practice Act on July 25, 1991;
5. Respondent had to request a hearing by August 26, 1991 in order for the board not to execute this final order; and
6. Respondent did not request a hearing by August 26, 1991.

B. The board further finds that

1. At all times relevant to these charges, the respondent was and is licensed to practice medicine in the state of Maryland;
2. Appropriate peer review includes the review of a physician's practice by a licensing or disciplinary authority of another jurisdiction;
3. On June 7, 1989, the Board of Registration in Medicine of the Commonwealth of Massachusetts issued a final decision and order in the matter of Peter J. Krokidas, M.D. with the following findings of fact, conclusions of law, and sanction and order:
 - a. Respondent failed to report to the Board of Registration his termination of hospital privileges at the Providence Hospital;
 - b. Respondent failed to report to the Board of Registration his suspension of his surgical and emergency room privileges at the Ludlow Hospital;
 - c. Respondent's surgical care fell below that of the average qualified practitioner practicing ophthalmology in 1979, when he failed to properly anesthetize a patient undergoing cataract surgery (Patient A);
 - d. Respondent falsely answered a question on his application for renewal of his hospital privileges at Wing Hospital regarding any past disciplinary action taken against him;
 - e. Respondent's treatment of a patient (Patient D) with laser photocoagulation therapy for macular edema caused by trauma fell below the standard of care for the average qualified ophthalmologist practicing in 1984;
 - f. Respondent's actual application of the laser treatment was not consistent with good medical practice in that the respondent did not enter power and wavelength settings, and the resultant scars demonstrated that the power that was used was greater than that normally used;
 - g. Respondent was denied privileges at the Newton-Wellesley

Hospital on the basis of misstatements he made on his application for staff privileges;

- h. Respondent's care of Patients A and D described above was negligent;
 - i. Respondent's care of Patient D was gross negligence which the Board of Registration defined as "very great negligence or the absence of slight diligence, or the want of even scant care;"
 - j. Respondent's practices demonstrated a lack of fitness and capacity to carry on the practice of medicine; and
 - k. Respondent provided false answers to procure his registration certificate;
4. Based upon those facts regarding patient care, the Board of Registration restricted respondent's license to practice medicine as follows:
 - a. Respondent may not engage in outpatient or inpatient surgical care, including but not limited to cataract surgery and laser photocoagulation treatment;
 - b. Respondent shall inform his existing patients, all subsequent patients, and all facilities with which he is affiliated of these restrictions on his practice;
 - c. Respondent's practice shall be under the aforementioned restrictions until respondent obtains a plan for supervision accepted by the board, recertification, or its equivalent in his specialty, and additionally demonstrates by clear and convincing evidence that he has remediated deficiencies of concern to the Board [of Registration of Medicine in the Commonwealth of Massachusetts] in this decision; and
 - d. The restrictions on respondent's practice shall continue until respondent provides evidence that health considerations do not impair his surgical practice;
 5. Providing false answers to procure a medical registration certificate is fraudulently or deceptively obtaining a license;
 6. Failure to report termination or restriction of hospital privileges as required by law is fraudulently or deceptively obtaining a license;
 7. Failure to report termination or restriction of hospital privileges as required by law is unprofessional conduct in the practice of medicine;
 8. Multiple negligent acts in the practice of medicine is practicing in a professionally incompetent manner;
 9. Multiple negligent acts in the practice of medicine is unprofessional conduct in the practice of medicine;
 10. Multiple negligent acts in the practice of medicine is a failure to meet appropriate standards of care;
 11. Committing acts of gross negligence in the practice of medicine is practicing medicine in a professionally incompetent manner;
 12. Committing acts of gross negligence in the practice of medicine is unprofessional conduct in the practice of medicine;
 13. Committing acts of gross negligence in the practice of medicine is a failure to meet appropriate standards of care;
 14. The restriction of respondent's right to practice medicine by the Board of Registration is being disciplined by a licensing or disciplinary authority; and

Board of Physician Quality Assurance Actions

15. The imposition of two fines of \$2,000 upon the respondent by the Board of Registration is being disciplined by a licensing or disciplinary authority.

Conclusions of law

Respondent committed the following prohibited acts:

1. Respondent was

Disciplined by a licensing or disciplinary authority or convicted or disciplined by a court of any state or country or disciplined by any branch of the United States uniformed services or the Veterans' Administration for an act that would be grounds for disciplinary action under this section, *MD Health Occ. Code Ann.* (Section 14-404 (a) (21));

2. The underlying grounds for this disciplinary action were respondent's actions by which he violated the following sections of *MD Health Occ. Code Ann.* Section 14-404 which authorize the board to discipline a licensee if the licensee

Fraudulently or deceptively obtains or attempts to obtain a license for the applicant or licensee or for another (Section 14-404 (a) (1) (1991));

Is guilty of immoral or unprofessional conduct in the practice of medicine (Section 14-404 (a) (3) (1991));

Is professionally, physically, or mentally incompetent (Section 14-404 (a) (4)); and

Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this state (Section 14-404 (a) (22)).

Order

It is this 10th day of September 1991, by an affirmative vote of a majority of the full authorized membership of those members of the board who considered this case,

ORDERED, that respondent's license to practice medicine in the state of Maryland is RESTRICTED; and be it further

ORDERED, that the restrictions upon respondent's license to practice medicine in the state of Maryland are identical to those placed upon his license to practice medicine in the commonwealth of Massachusetts; and be it further

ORDERED, that respondent shall not practice medicine in the state of Maryland until respondent appears before a settlement conference of the board and obtains the approval of the board; and be it further

ORDERED, that this is a final order and as such will be considered a public document pursuant to *MD State Gov't Code Ann.* Section 10-611 *et seq.* (1989 Cum. Supp.).

ISRAEL H. WEINER MD, Chairperson
Maryland Board of Physician Quality Assurance

Notice of right to appeal

Pursuant to *MD Health Occ. Code Ann.* Section 14-408 (b) (1991) there is a right to take a direct judicial appeal. Any appeal shall be made as provided for in judicial review of a final decision in the Administrative Procedure Act, State Government Article and the B Rules of Maryland Procedure, 1991.

ISRAEL H. WEINER MD, Chairperson
Maryland Board of Physician Quality Assurance

■ ■ ■
In the matter of
John J. Shigo, M.D.
before the
Maryland Board of
Physician Quality Assurance

Order terminating probation and reinstating license

By order (Appendix B) dated June 21, 1988, the Commission on Medical Discipline (the commission, predecessor agency to the Board of Physician Quality Assurance) found under the criteria of State Government Article §10-405(b) that it was necessary to order the summary suspension of John J. Shigo, M.D.'s (the respondent) license to practice medicine. By order (Appendix A) dated October 24, 1988, the Board of Physician Quality Assurance (the board) stayed the summary suspension of respondent's license to practice medicine, conditioned upon the respondent complying with conditions of probation (the conditions of probation).

By letter dated December 3, 1990, respondent petitioned the board for termination of probationary status and reinstatement of his license (petition) to practice medicine in Maryland. At its meeting on June 12, 1991, the board, through its case resolution conference (the conference), reviewed respondent's petition. Based upon the board's review of the petition, the board determined that respondent had fulfilled the conditions of probation contained in the October 24, 1988 order.

Findings of fact and conclusions of law

The board concludes, as a matter of law, that respondent has satisfactorily complied with all conditions of probation as set forth in the order of October 24, 1988.

Order

Upon the foregoing findings of fact and conclusions of law, it is this 10th day of September 1991 by a majority vote of the full authorized membership of the board

ORDERED, that effective as of the date of this order, the conditions of probation imposed upon respondent's practice of medicine by the board's 1988 order are hereby TERMINATED and of no further force and effect; and be it further

ORDERED, that respondent's license to practice medicine

Board of Physician Quality Assurance Actions

in the state of Maryland be REINSTATED without any condition or restriction whatsoever; and be it further

ORDERED, that this is a final order and as such is considered a public document pursuant to the Maryland Public Information Article, State Government Article, *Annotated Code of Maryland*, §§10-611 *et seq.*, specifically §10-617(h)(2)(vi).

ISRAEL H. WEINER MD, Chairperson
Maryland Board of Physician Quality Assurance

Appendix A

In the matter of
John J. Shigo, M.D.
before the
Maryland Board of
Physician Quality Assurance

Findings of fact, conclusions of law, and recommendation

Based on information received regarding the recent hospitalization of John J. Shigo, M.D., (the respondent), the Commission on Medical Discipline (the commission) ordered that the respondent's license to practice medicine in the state of Maryland be summarily suspended. This order of June 21, 1988, further required the surrender of certain documents certifying the respondent's entitlement to practice medicine in Maryland. He was also directed to submit to a psychiatric evaluation conducted by Jonas R. Rapoport, M.D. Finally, the commission ordered that a hearing be held within thirty days of the date upon which the commission received a written request for such a hearing from the respondent. The respondent's request for a hearing was received on July 1, 1988, and a hearing was held on July 14, 1988, in Room L-9 at 201 West Preston Street, Baltimore, Maryland 21201 before a hearing officer of the Office of Administrative Hearings and Appeals. The respondent and his counsel, Nelson Ongelia, Esq., were present. The Board of Physician Quality Assurance (the board) was represented by Alice D. Ike, Esq., assistant attorney general. Dr. Jonas R. Rapoport testified on behalf of the board.

The following exhibits of the board were admitted into the record during the hearing without objection:

Exhibit A. Letter to board from Jonas R. Rapoport, M.D., dated July 12, 1988.

Exhibit B. Psychiatric evaluation of John Shigo, M.D., by Jonas R. Rapoport, M.D., dated July 12, 1988.

Exhibit C. Curriculum vitae, Jonas R. Rapoport, M.D.

Exhibit D. Letter addressed to whom it may concern from Gustave J. Weiland, M.D., dated June 28, 1988.

The following exhibits of the respondent were admitted into the record during the hearing without objection:

Exhibit 1. Letter addressed to whom it may concern from Gustave J. Weiland, M.D., dated June 28, 1988. (This exhibit is the same as exhibit D above).

Exhibit 2. Letter to Dr. Shigo from Alayne M. Connell, dated April 29, 1988.

Exhibit 3. Letter to Dr. Shigo from Jay Corbino, dated April 22, 1987.

Exhibit 4. Letter to Dr. Shigo from D. Freeman Carroll, dated April 22, 1988.

Exhibit 5. Documents extracted from the medical records at Holy Cross Hospital of Silver Spring pertaining to the admission of Dr. Shigo on June 4, 1988 and treatment provided thereafter. These documents include progress notes; patient's discharge instruction record; medication administration records; treatment and/or drug records; nursing progress notes; aftercare-plan discharge record; patient property list; interdisciplinary treatment plan; and patient care plan.

Exhibit 6. Minnesota Multiphasic Personality Inventory clinical report regarding John Shigo, dated March 3, 1988.

The parties stipulated to certain facts together with fourteen exhibits associated therewith. These joint exhibits were admitted into the record during the hearing without objection. Joint exhibit 15 was also stipulated and admitted independently of a specific factual stipulation.

Joint exhibit 1. Nursing data base/systems assessment, dated May 30, 1988.

Joint exhibit 2. History and physical, John J. Shigo, by Pimol Limpuangthip, M.D., dated May 30, 1988.

Joint exhibit 3. Doctors' Hospital of Prince George's County (hereinafter, Prince George's Hospital) admission note, John J. Shigo, dated May 30, 1988.

Joint exhibit 4. Documents from medical records of John J. Shigo, Prince George's Hospital, including progress notes; urinalysis report; toxicology screening report; and urine and blood culture reports, dated June 6 and June 9, 1988.

Joint exhibit 5. Physician's orders, Prince George's Hospital, John J. Shigo, dated June 3, 1988.

Joint exhibit 6. Physician's order, Prince George's Hospital, John J. Shigo, dated June 4, 1988.

Joint exhibits 7 and 8. These were not proffered by the parties. (The numbering sequence of following joint exhibits was not changed in order to keep the exhibit identification consistent with the hearing transcript).

Joint exhibit 9. Medical record, Prince George's Hospital, John Shigo, dated January 21, 1988.

Joint exhibit 10. Progress notes, Prince George's Hospital, John Shigo, dated January 22, 1988.

Joint exhibit 11. Emergency service record, physician signed but not dated.

Joint exhibit 12. Admitting record, Prince George's Hospital, John Shigo, dated January 21, 1988.

Joint exhibit 13. Patient transfer form, Prince George's Hospital to Sheppard Pratt, John Shigo, dated January 26, 1988.

Joint exhibit 14. Discharge summary by Carl H. Keller, M.D., John Shigo, dated January 26, 1988.

Joint exhibit 15. Medical records obtained from Holy Cross Hospital of Silver Spring and Prince George's Hospital in response to subpoenas duces tecum issued by the Commission on Medical Discipline in June, 1988. This exhibit also includes two letters to Margaret T. Anzalone from Gustave J. Weiland, M.D., and James D. Peacock, Esq., dated June 29 and 28, 1988, respectively.

By letter dated August 25, 1988, respondent's attorney was forwarded a copy of the hearing officer's proposed findings of fact,

Board of Physician Quality Assurance Actions

conclusions of law, and recommendation (proposed order). Respondent chose not to except the hearing officer's proposed order. On Wednesday, October 12, 1988, the Board of Physician Quality Assurance (the board) considered the entire record and the hearing officer's proposed decision. By a unanimous vote of the board members considering this case, the board makes the following findings of fact, conclusions of law, and order.¹

Findings of fact

1. Prior to June 21, 1988, the respondent was engaged in the practice of medicine in the state of Maryland.
2. In March, 1986, the respondent's parents were found dead in their home as a result of accidental asphyxiation. (See board exhibit B.)
3. Since graduating from medical school in 1969, the respondent has been married and divorced twice, the latest in 1987. (See board exhibit B.)
4. In 1985, following the respondent's separation from his second wife, considerable and costly litigation ensued regarding a settlement agreement, child support, and related matters. (See board exhibit B.)
5. In or about April 1987, the respondent sought relief from the stress and pressures of domestic strife and litigation by giving up his medical practice of sixteen years and moving to Bernuda for approximately two months. (See board exhibit B.)
6. In or about July 1987, the respondent returned to the Washington metropolitan area and retook the family practice specialty medical board examination. (See board exhibit B.)
7. After taking his specialty board examination, the respondent attended a medical meeting in India with his girlfriend. (See board exhibit B.)
8. The respondent extended his stay in India to avoid the stress of litigation and further argument surrounding his divorce. (See board exhibit B.)
9. In September 1987, the respondent returned to the United States and attended a California meeting of the American Academy of Family Practice. (See board exhibit B.)
10. In October 1987, the respondent visited his daughter in Charleston, South Carolina. (See board exhibit B.)
11. While in Charleston, the respondent was arrested on a fugitive warrant issued in Maryland because of child support arrearage. (See board exhibit B.)
12. Upon his return to Maryland, the respondent was incarcerated for ten days. (See board exhibit B.)
13. When released, the respondent lived in an apartment constructed in a house jointly owned with Mr. J.P. Rickett, C.P.A., respondent's accountant. (See board exhibit B.)
14. Mr. Rickett and the respondent had a business association with regard to the respondent's medical practice in Bowie, Maryland. (See board exhibit B.)
15. The respondent gave Mr. Rickett his general power of attorney under which Mr. Rickett had arranged for other physicians to manage the respondent's medical practice in Bowie while he was away from the Washington metropolitan area. (See board exhibit B.)
16. The respondent did not return to his medical practice in Bowie because it appeared that some patients believed he had deserted them. (See board exhibit B.)
17. The respondent then worked as a physician for Kaiser Permanente in Kensington, Maryland, but left the position after one month because he believed there was inadequate staff support. (See board exhibit B.)
18. At that point, the respondent felt anxious and depressed for a number of reasons. In addition to the recency of his parents' deaths, he had to go back to court for the final settlement of his divorce, he was in arrears on child support, he had given up a sixteen-year medical practice in Bowie, he did not want to go into court without a job, Mr. Rickett indicated he was "washed up" in Bowie and wanted him to take over a practice in Accokeek, and the Internal Revenue Service was investigating the withdrawal of funds from his pension plan.² (See board exhibit B.)
19. On or about January 21, 1988, at around 6:00 p.m., the respondent was found unconscious in his home at 11800 Galaxy Lane, Bowie, Maryland, by a friend. Four syringes were found next to the respondent. (See joint exhibit 9.)
20. The respondent had attempted suicide by injecting significant quantities of Tramxene, Phenergan, and Demerol IV into his body. (See board exhibit B.)
21. On or about January 21, 1988, the respondent was transported via medic unit to Prince George's Hospital. Throughout the transport and upon his admittance to the hospital's emergency room at approximately 10:17 p.m., the respondent remained comatose, exhibited pinpoint pupils bilaterally, and was unresponsive to deep pain stimuli.
22. In connection with the respondent's admission to Prince George's Hospital on or about January 21, 1988, a drug screen was performed from samples of his blood and urine. The drug screen was positive for benzodiazepines and opiates. (See joint exhibit 10.)
23. A physical examination of the respondent upon admission to the hospital on or about January 21, 1988, revealed fresh multiple needle marks on bilateral antecubital fossae with related ecchymosis. (See joint exhibit 11.)
24. Upon respondent's admission to Prince George's Hospital, his medical diagnosis was drug overdose. (See joint exhibit 12.)
25. The respondent remained a patient in Prince George's Hospital until his transfer to the Sheppard Pratt Hospital (hereinafter, Sheppard Pratt) on January 26, 1988.
26. Sheppard Pratt is a private psychiatric hospital located in the state of Maryland.
27. At the time of the respondent's transfer to Sheppard Pratt on January 26, 1988, the patient transfer form listed his diagnoses as an overdose with opiates and benzodiazepines, as well as an adjustment disorder with mixed reaction. (See joint exhibit 13.)
28. Upon the respondent's transfer to Sheppard Pratt, Dr. Carl H. Keller, a psychiatrist on staff at Prince George's Hospital, prepared a discharge summary. The summary reveals that the respondent "...denied making a suicide attempt or that he wanted

1. Prior to the board's considering the record, respondent, through his attorney, agreed to be examined by Jonas R. Rapoport, M.D., and have the board's chairperson, Israel H. Weiner, M.D., report to the board orally regarding Dr. Rapoport's finding. The board considered this information.

2. The respondent alleged that his former wife embezzled about \$150,000 from his pension plan and that he had been providing her with \$3,850 a month for support.

Board of Physician Quality Assurance Actions

- to die" and listed diagnoses of adjustment disorder and depressed mood. (See joint exhibit 14.)
29. While at Sheppard Pratt, Dr. Joseph Chambers of Physicians Rehabilitation contacted the respondent and arranged for his therapy with Dr. Harvey Fernbach. (See board exhibit B.)
30. Upon release from Sheppard Pratt, the respondent began treatment with Dr. Fernbach and also tried to open his own practice in Bowie. (See board exhibit B.)
31. Conflicts arose between the respondent's girlfriend, who was acting as the office manager of the new practice, and Mr. Rickett. This conflict created more stress and anxiety for the respondent. (See board exhibit B.)
32. In the interim, the local medical society required the respondent to see Dr. Richard Anderson, a Baltimore psychiatrist. (See board exhibit B.)
33. Dr. Anderson opined that the respondent's problems related to his relationship with and dependency on Mr. Rickett. (See board exhibit B.)
34. Thus, several major stressors were acting on the respondent at that point: namely, his dependency on Mr. Rickett, who still had control of the respondent's money; the slowness of the buildup of his medical practice; the conflict between his girlfriend and Mr. Rickett; and the girlfriend's threat to leave if the respondent did not cut his ties with Mr. Rickett. The respondent felt he was unable to get everything under control. (See board exhibit B.)
35. On or about May 30, 1988, the respondent went into the garage of a friend he was staying with, started the car, put a blanket on the ground, took twenty-five 25 mg. Phenergan capsules and four 15 mg. Restoril tablets, ran around to quicken absorption of the medicine, and then lay down next to the engine exhaust pipe. He started to choke, ran out of the garage, and fell down on the lawn where his daughter found him. (See board exhibit B.)
36. On May 30, 1988, the respondent was transported via medic unit from his friend's residence at 7000 Highbridge Road, Bowie, Maryland, to the AMI Doctors' Hospital of Prince George's (hereinafter, Doctors' Hospital).
37. On May 30, 1988, at approximately 3:15 a.m. when admitted to Doctors' Hospital, the respondent was comatose. (See joint exhibit 1.)
38. Upon the respondent's admission through the emergency room of Doctors' Hospital, it was revealed that the respondent was previously seen by a psychiatrist and experienced a prior drug overdose. (See joint exhibit 2.)
39. The admission note prepared at the time of the respondent's admission to Doctors' Hospital listed the reasons for admission as an overdose of benzodiazepine and carbon monoxide poisoning. (See joint exhibit 3.)
40. The presence of benzodiazepine was noted in samples of the respondent's blood and urine collected at the time of his admission on May 30, 1988. (See joint exhibit 4.)
41. When the respondent was transferred to a private room at Doctors' Hospital on June 3, 1988, the physicians' orders contained instructions for a twenty-four-hour sitter with the patient, either hospital or agency personnel. (See joint exhibit 5.)
42. Physicians' orders for the respondent's care dated June 4, 1988, contained instructions to continue the twenty-four-hour sitter and suicidal precautions. (See joint exhibit 6.)
43. During his hospitalization, the respondent was referred to Dr. Gustave Weiland, a board certified psychiatrist, who began psychotherapy and continues to see the respondent twice a week. (See board exhibit B.)
44. On or about June 21, 1988, the then Commission on Medical Discipline, summarily suspended the respondent's license to practice medicine in the state of Maryland, ordered that a hearing be held to consider the emergency suspension, and directed the respondent to appear for a psychiatric evaluation by Jonas R. Rapoport, M.D. (See commission's order dated June 21, 1988.)
45. The respondent was interviewed and evaluated by Jonas R. Rapoport, M.D., on July 11, 1988. (See board exhibits A and B.)
46. Dr. Rapoport stated that the respondent suffers from a bipolar disorder with two clear depressive episodes and possible hypomanic episodes. Dr. Rapoport also found that at the time, there was sufficient hypomania and evidence of poor judgment to cause him to believe the respondent should not practice medicine at that time. (See board exhibits A and B.)
47. Dr. Rapoport stated that suspension of the respondent's license on an emergency basis was appropriate and the justifying conditions continue to exist. (See board exhibit B.)
48. Dr. Rapoport expressed his professional opinion that the respondent's license not be returned to him immediately, that he undergo a period of continued treatment, that he attempt to stabilize his life situation and finances before his license is returned, that when the respondent returns to practice he should practice under the supervision of, or in relationship to, other physicians, not as a solo practitioner. (See board exhibit B.)
49. Dr. Rapoport stated further that the respondent must remain under psychiatric care and take appropriate medications for at least another year, if not longer. (See board exhibit B.)
50. Finally, Dr. Rapoport testified that suspension of the respondent's license could be removed in thirty to sixty days from July 14, 1988, provided the respondent's other life situations or stressors have been appropriately reduced or eliminated.
51. The respondent, via counsel, testified that the litigation surrounding his divorce settlement and child support has been finalized.
52. The respondent has removed himself from the prior stressful living situation, had moved to another locale, and has broken his relationship with Mr. Rickett.
53. The respondent has rented and moved into a townhouse in Georgetown and continues with psychiatric care including group therapy. (See board exhibit B.)
54. In his letter of June 28, 1988, Dr. Weiland stated that in his professional judgment, the respondent is well and able to practice medicine without any limitations. (See respondent exhibit 1.)
55. On October 11, 1988, Dr. Rapoport examined respondent and opined that respondent could return to practice in a group setting if respondent continues in the therapeutic relationship with Dr. Weiland.

Conclusions of law

State Government Article §10-405(b), *Annotated Code of Maryland*, provides in pertinent part that a unit [of the state government] may order summarily the suspension of license if the unit

- (1) finds that the public health, safety, or welfare imperatively requires emergency action; and
- (2) promptly give the licensee:
 - (i) written notice of the suspension, the findings, and the reasons that support the findings; and
 - (ii) an opportunity to be heard.

Board of Physician Quality Assurance Actions

Based on the above findings of fact, it is concluded that the public health, safety, and welfare required that respondent's license be summarily suspended.

Order

Based upon the findings of fact and conclusions of law, it is hereby ORDERED this 24th day of October 1988, that the summary suspension of respondent's license to practice medicine is hereby STAYED, subject to respondent's compliance with the following conditions:

1. Respondent shall remain in psychiatric care and comply with all recommendations of his therapist;
2. Respondent shall only practice medicine in conjunction with other licensed physicians in a practice setting approved by the board;
3. The respondent shall arrange for respondent's therapist to submit written monthly reports to a representative of the board commencing one month after the date of this order, indicating that respondent is making satisfactory progress in dealing with the problems that led to his license being summarily suspended, the number of times a month respondent is in therapy, any medications being taken, and whether respondent is complying with all medical recommendations of the therapist;
4. The respondent shall continue in therapy until the therapist certifies to the board's representative in writing that the respondent is discharged;
5. In the event that the respondent terminates therapy prior to discharge by the respondent's therapist, the therapist shall immediately notify the board's representative that respondent has left therapy without consent of the therapist;
6. The board's representative shall prepare for Dr. Rapoport (or a board-approved psychiatrist) to review a summary of the therapist's reports when respondent petitions the board for reinstatement of his license;
7. In the event that the therapist's reports indicate that respondent is not complying with the therapist's recommendations, that respondent has terminated therapy against the advice of his therapist, or that respondent is a danger to himself or the public health, safety, or welfare, the board's representative will report IMMEDIATELY to the board;
8. In the event that the Board's representative does not receive the required reports, due starting on November 30, 1988, and due thereafter on the 30th of the month, until a year has passed from respondent's approved employment commencing, the board's representative will notify the board within five days of failing to receive the report;
9. In the event that respondent moves permanently or temporarily, respondent shall promptly notify the Board of Physician Quality Assurance in writing of respondent's new address and telephone number during the probationary period;
10. The respondent shall practice in accordance with the laws and regulations governing the practice of medicine in Maryland; and be it further

ORDERED, one year from the date the board approves respondent's job description, respondent may petition the board to remove any conditions of his license to practice medicine in Maryland. Prior

to any decision being made by the board on said petition, respondent shall submit to an examination by Jonas R. Rapoport, M.D. or another psychiatrist approved by the board. At that time, if the board determines that a vacating of the suspension would not be appropriate, the board may impose other conditions. If the respondent has complied with all conditions, and if there are no outstanding complaints against respondent's practice, the board will reinstate the respondent's license without any conditions or restrictions whatsoever; and be it further

ORDERED, that respondent's license to practice medicine and his federal and state permits to prescribe controlled dangerous substances and legend drugs are restored, subject to the above conditions; and be it further

ORDERED, that if the board receives a report from respondent's therapist or the board's representative indicating that respondent is a danger to himself or to the public safety, health, or welfare, or if respondent has terminated therapy against the advice of his therapist, the board, WITHOUT PRIOR NOTICE AND AN OPPORTUNITY TO BE HEARD MAY LIFT THE STAY OF SUMMARY SUSPENSION ON RESPONDENT'S LICENSE, provided that respondent is given immediate notice of the charges and an opportunity for a hearing thirty days after requesting same; and be it further

ORDERED, that if respondent violates any other term of this order, the board, after notice and a hearing, and a determination of violation, may lift the stay of SUMMARY SUSPENSION of respondent's license or may impose any other disciplinary sanction it deems appropriate; and be it further

ORDERED, that this is a final order and as such is considered a public document pursuant to State Government Article of the *Annotated Code of Maryland*, §§10-611, *et seq.*

ISRAEL H. WEINER MD, Chairperson
Maryland Board of Physician Quality Assurance

Appendix B

In the matter of
John J. Shigo, M.D.
before the Commission
on Medical Discipline

Order for emergency suspension of medical license

Based on information received regarding the recent hospitalization of JOHN J. SHIGO (the respondent), the Commission on Medical Discipline (the commission) makes the following findings of fact, conclusion of law, and order.

Findings of fact

Based upon all the information known and available to it, the commission has reason to believe that

1. Respondent is a physician licensed to practice medicine in the state of Maryland.
2. On May 30, 1988, respondent was found unconscious on the grass outside the garage of his residence by his daughter, Monica Shigo. The garage light was on and the car engine was still running inside the garage. No medication was found near respondent or in or around the house.
3. On May 30, 1988, respondent was transported via medic unit from his residence, 11800 Galaxy Lane, Bowie, to the AMI Doctors' Hospital of Prince George's.
4. On May 30, 1988, at approximately 3:15 a.m., when respondent

Board of Physician Quality Assurance Actions

was admitted to AMI Doctors' Hospital of Prince George's through the emergency room, respondent was not conscious. A copy of report noting respondent's status upon admission is attached as exhibit 1.

5. On May 30, 1988, upon respondent's admission through the emergency room of AMI Doctors' Hospital of Prince George's, a past history of psychiatric care and drug overdose using Demerol IV was noted. A copy of the history and physical taken is exhibit 2.
6. On May 30, 1988, upon respondent's admission through the emergency room of AMI Doctors' Hospital of Prince George's, the reasons for admission as listed on the admitting note were (1) overdose of benzodiazepine and (2) carbon monoxide poisoning. A copy of the admitting note signed by Pimol Limpuangthip, M.D. is exhibit 3.
7. On May 30, 1988, upon respondent's admission through the emergency room of AMI Doctors' Hospital of Prince George's, blood and urine samples were taken. Analysis of respondent's blood and urine noted the presence of benzodiazepine. A copy of the relevant reports and notes is exhibit 4.
8. On June 3, 1988, respondent was transferred to a private room at AMI Doctors' Hospital of Prince George's. The physicians' orders dated June 3, 1988 contain instructions for a twenty-four-hour sitter with the patient — hospital or agency personnel. A copy of the June 3, 1988 physicians' orders is exhibit 5.
9. Physicians' orders for respondent's care at AMI Doctors' Hospital of Prince George's dated June 4, 1988 contain instructions to continue twenty-four-hour sitter and suicidal precautions. A copy of the June 4, 1988 physicians' orders is exhibit 6.
10. The facts and circumstances surrounding the events of May 30, 1988, when considered with respondent's age and previous history of attempted suicide by injection of Demerol, support a finding that on May 30, 1988, respondent attempted suicide.
11. Respondent's apparent suicide attempt on May 30, 1988 as described above suggests the existence of a diagnosable illness.

12. Respondent's apparent suicide attempt on May 30, 1988 as described above indicates that respondent either lacks good judgment or that his judgment is impaired, thus placing at risk patients whom respondent may treat.

Conclusion of law

Based upon the foregoing facts, the commission finds that the public health, safety, and welfare imperatively require emergency action in this case, pursuant to State Government Article, §10-405(b), *Annotated Code of Maryland*.

Order

It is this 21st day of June 1988 by the Commission on Medical Discipline

ORDERED, that pursuant to the authority vested in the commission by State Law Article, §10-405 of the *Annotated Code of Maryland*, respondent's license to practice medicine in the state of Maryland is hereby SUMMARILY SUSPENDED; and be it further

ORDERED, that upon presentation of this order, respondent shall immediately deliver to the commission's executive director (1) his diploma-sized certificate from the Board of Medical Examiners, (2) his current Department of Health and Mental Hygiene license renewal certificate, and (3) his current wallet-size license renewal card; and be it further

ORDERED, that a hearing to consider this emergency suspension shall be held before the commission within thirty days of the date upon which the commission receives a written request for such a hearing from the respondent; and be it further

ORDERED, that, in accordance with Section 14-502 of the Health Occupations Article, *Annotated Code of Maryland*, respondent is directed by the Commission on Medical Discipline to appear at the office of Jonas R. Rappeport, M.D., Professional Arts Building, 101 W. Read Street, Baltimore, Maryland 21202 at 1:30 p.m. on Monday, July 11, 1988, for the purpose of a psychiatric evaluation.

HILARY T. O'HERLIHY, M.D., Chairperson
Commission on Medical Discipline

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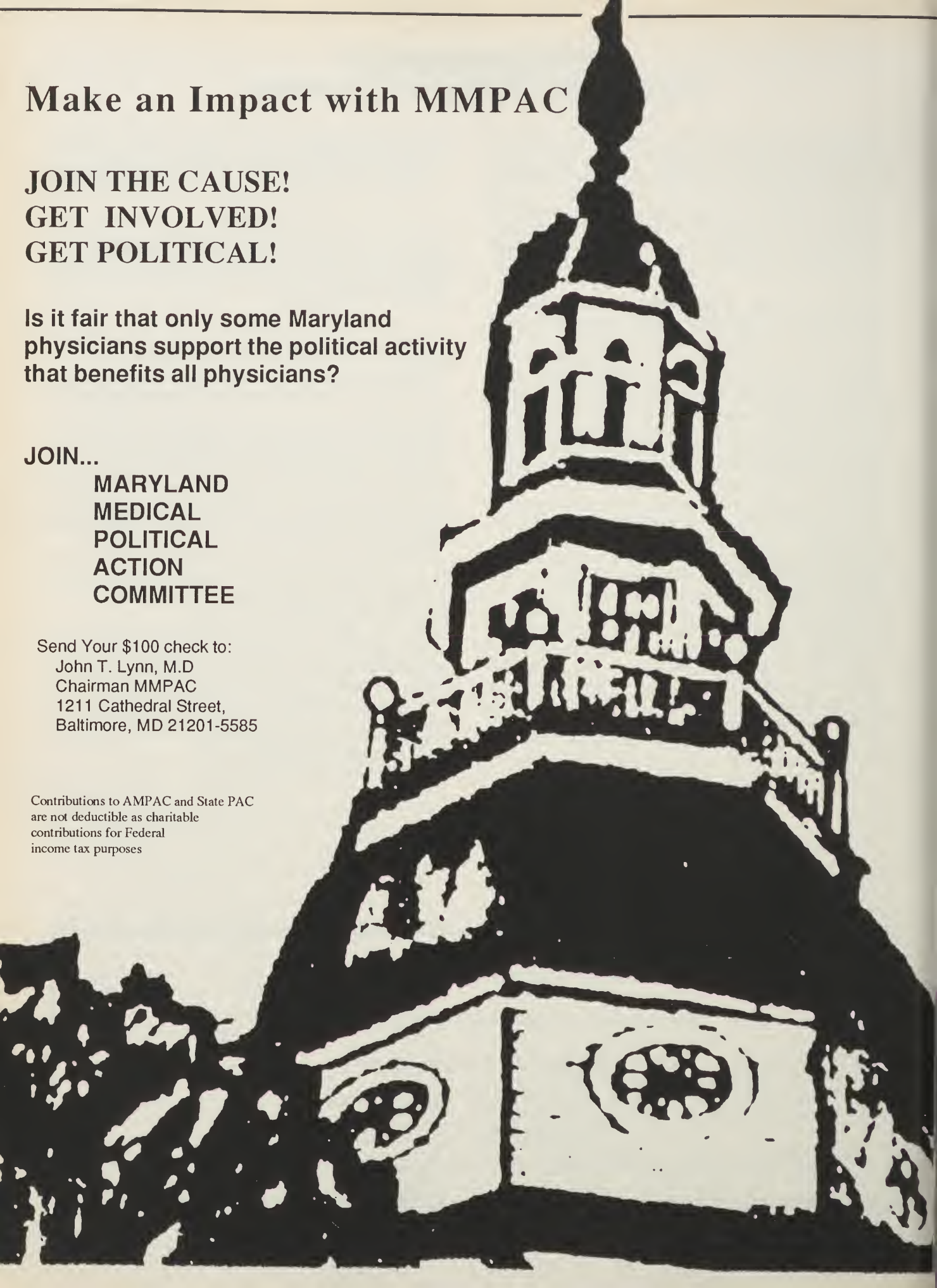
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OSHA Final Rule on Occupational Exposure to Bloodborne Pathogens

March, 1992

The Occupational Safety and Health Administration (OSHA) final rule on Occupational Exposure to Bloodborne Pathogens was published in the Federal Register, December 6, 1991. This standard, summarized in the OSHA Fact Sheet on the following pages, will affect more than 5.6 million U.S. workers, three-quarters of whom are employed in health care. The regulations specify requirements for employers to protect employees from exposure to bloodborne pathogens including but not limited to hepatitis B virus and human immunodeficiency virus (HIV).

The Occupational Safety and Health Act of 1970 dictated the employer's obligation to provide a safe work place. Historically OSHA has regulated chemical and mechanical hazards. This standard marks the first time that OSHA has adopted a standard for a biological hazard. Maryland Occupational Safety and Health (MOSH), the office charged with interpreting and enforcing OSHA regulations must adopt regulations comparable to the OSHA standard by June 4, 1992. By Maryland law, MOSH regulations cover both private and public sector employers. MOSH has the authority to cite and fine employers who are not in compliance with regulations.

The new standard mandates engineering controls (e.g., sharps disposal containers, self-sheathing needles), work practices, personal protective equipment and employee training which will reduce on-the-job risks for employees exposed to blood and other potentially infectious materials. In addition, the standard requires that employers offer pre-exposure hepatitis B vaccination, at no cost, to all

employees with the potential for occupational exposure.

Until the new regulations go into effect, MOSH will continue to conduct inspections, both as general schedule inspections and as the result of complaints or referrals, to determine the existence of a program to minimize the potential for employee exposure to blood and body fluids.

Copies of the December 6, 1991 Federal Register (Volume 56, Number 235) may be obtained from the United States Government Printing Office, Superintendent of Documents, Washington, D.C. 20402, (202) 523-9667. The Maryland Medical and Chirurgical Society Subcommittee on Immunization and Infectious Disease addressed this issue on February 11, 1992. The Commissioner of Labor and Industry will hold a hearing on whether to adopt for Maryland the Standard as promulgated by OSHA. The tentative date for the hearing is Tuesday, March 31, 1992, at 10:00 a.m. in Hearing Room Number 15, First Floor, 501 St. Paul Place, Baltimore, Maryland. The Commissioner will publish formal notice, together with a definite hearing date, in the Maryland Register. The Commissioner will accept both written comments and testimony. Address written comments to the Commissioner at the address listed above. If you wish to be placed on the hearing agenda, please contact either Doris Wright, secretary to the Board, or Carolyn West, Regulations Coordinator, no later than March 27, 1992, at (410) 333-4184.

Fact Sheet

OSHA Bloodborne Pathogens Final Standard

Summary of Key Provisions

Purpose:

Limits occupational exposure to blood and other potentially infectious materials since any exposure could result in transmission of bloodborne pathogens which could lead to disease or death.

Scope:

Covers all employees who could be "reasonably anticipated", as the result of performing their job duties, to face contact with blood and other potentially infectious materials. OSHA has not attempted to list all occupations where exposures could occur. "Good Samaritan" acts such as assisting a co-worker with a nosebleed would not be considered occupational exposure.

Infectious materials include semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid visibly contaminated with blood and all body fluids in situations where it is difficult or impossible to differentiate between body fluids. They also include any unfixed tissue or organ other than intact skin from a human (living or dead) and human immunodeficiency virus (HIV) - containing cell or tissue cultures, organ cultures and HIV or hepatitis B (HBV) - containing culture medium or other solutions as well as blood, organs or other tissues from experimental animals infected with HIV or HBV.

Exposure Control Plan:

Requires employers to identify, in writing, tasks and procedures as well as job classifications where occupational exposure to blood occurs--without regard to personal protective clothing and equipment. It must also set forth the schedule for implementing other provisions of the standard and specify the procedure for evaluating circumstances surrounding exposure incidents. The plan must be accessible to employees and available to OSHA. Employers must review and update it at least annually--more often if necessary to accommodate workplace changes.

Methods of Compliance:

Mandates universal precautions (treating body fluids/materials as if infectious) emphasizing engineering and work practice controls. The standard stresses handwashing and requires employers to provide facilities and ensure that employees use them following exposure to blood. It sets forth procedures to minimize needlesticks, minimize splashing and spraying of blood, ensure appropriate packaging of specimens and regulated wastes and to decontaminate equipment or label it as contaminated before shipping to servicing facilities.

Employers must provide, at no cost, and require employees to use appropriate personal protective equipment such as gloves, gowns, masks, mouthpieces and resuscitation bags and must clean, repair and replace these when necessary. Gloves are required for phlebotomy except in volun-

teer blood donation centers, where gloves must be made available to employees who want them.

The standard requires a written schedule for cleaning, identifying the method of decontamination to be used, in addition to cleaning following contact with blood or other potentially infectious materials. It specifies methods for disposing of contaminated sharps and sets forth standards for containers for these items and other regulated waste. Further, the standard includes provisions for handling contaminated laundry to minimize exposures.

HIV and HBV Research Laboratories and Production Facilities:

Calls for these facilities to follow standard microbiological practices and specifies additional practices intended to minimize exposures of employees working with concentrated viruses and reduce the risk of accidental exposure for other employees at the facility. These facilities must include required containment equipment and an autoclave for decontamination of regulated waste and must be constructed to limit risks and enable easy clean up. Additional training and experience requirements apply to workers in these facilities.

Hepatitis B Vaccination:

Requires vaccinations to be made available to all employees who have occupational exposure to blood within 10 working days of assignment, at no cost, at a reasonable time and place, under the supervision of licensed physician/licensed healthcare professional and according to the latest recommendations of the U.S. Public Health Service (USPHS). Prescreening may not be required as a condition of receiving the vaccine. Employees must sign a declination form if they choose

not to be vaccinated, but may later opt to receive the vaccine at no cost to the employee. Should booster doses later be recommended by the USPHS, employees must be offered them.

Post-Exposure Evaluation and Follow-up:

Specifies procedures to be made available to all employees who have had an exposure incident plus any laboratory tests must be conducted by an accredited laboratory at no cost to the employee. Follow-up must include a confidential medical evaluation documenting the circumstances of exposure, identifying and testing the source individual if feasible, testing the exposed employee's blood if he/she consents, post-exposure prophylaxis, counseling and evaluation of reported illnesses. Healthcare professionals must be provided specified information to facilitate the evaluation and their written opinion on the need for hepatitis B vaccination following the exposure. Information such as the employee's ability to receive the hepatitis B vaccine must be supplied to the employer. All diagnoses must remain confidential.

Hazard Communication:

Requires warning labels including the orange or orange-red biohazard symbol affixed to containers of regulated waste, refrigerators and freezers and other containers which are used to store or transport blood or other potentially infectious materials. Red bags or containers may be used instead of labeling. When a facility uses universal precautions in its handling of all specimens, labeling is not required within the facility. Likewise, when all laundry is handled with universal precautions, the laundry need not be labeled. Blood which has been tested and found

free of HIV and HBV and released for clinical use, and regulated waste which has been decontaminated, need not be labeled. Signs must be used to identify restricted areas in HIV and HBV research laboratories and production facilities.

Information and Training:

Mandates training within 90 days of effective date, initially upon assignment and annually--employees who have received appropriate training within the past year need only receive additional training in items not previously covered. Training must include making accessible a copy of the regulatory text of the standard and explanation of its contents, general discussion on bloodborne diseases and their transmission, exposure control plan, engineering and work practice controls, personal protective equipment, hepatitis B vaccine, response to emergencies involving blood, how to handle exposure incidents, the post-exposure evaluation and follow-up program, signs/labels/color-coding. There must be opportunity for questions and answers, and the trainer must be knowledgeable in the subject matter. Laboratory and production facility workers must receive additional specialized initial training.

Recordkeeping:

Calls for medical records to be kept for each employee with occupational exposure for the duration of employment plus 30 years, must be confidential and must include name and social security number; hepatitis B vaccination status (including dates); results of any examinations, medical testing and follow-up procedures; a copy of the healthcare professional written opinion; and a copy of information provided to the healthcare professional.

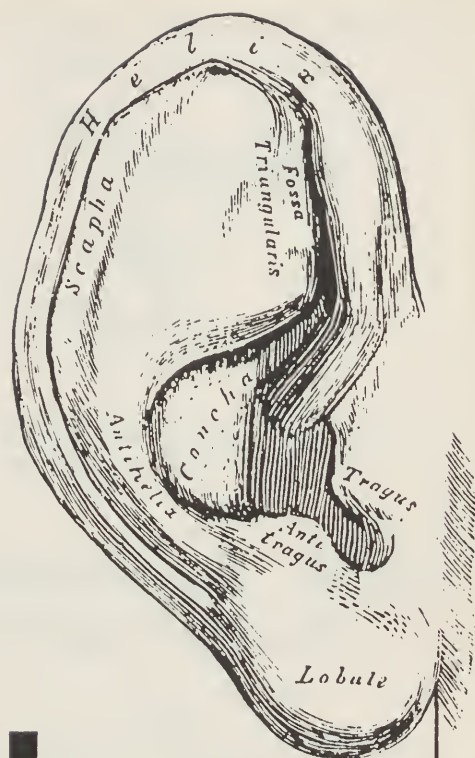
Training records must be maintained for three years and must include dates, contents of the training program or a summary, trainer's name and qualifications, names and job titles of all persons attending the sessions. Medical records must be made available to the subject employee, anyone with written consent of the employee, OSHA and NIOSH--they are not available to the employer. Disposal of records must be in accord with OSHA's standard covering access to records.

Dates:

Sets effective date 90 days after publication in the Federal Register. Exposure control plan must be completed within 60 days of the effective date. Information and training requirements take effect 90 days following the effective date. And the following other provisions take effect 120 days after the effective date: engineering and work practice controls, personal protective equipment, housekeeping, special provisions covering HIV and HBV research laboratories and production facilities, hepatitis B vaccination and post-exposure evaluation and followup and labels and signs.

Produced by Occupational Safety and Health Administration, December, 1991, adapted by Epidemiology and Disease Control Program.

2/92



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Med Chi's new publication, *Physician's Practice Digest*, covers financial management tips...office management...new laws and regulations...insurance issues...computer news...lifestyle ideas...and more!

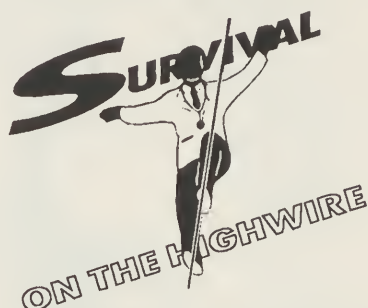
We want to address the issues you want to hear about. If you have ideas for topics to be covered or would like to submit an article, write to Editor, *PPD*, 1211 Cathedral Street, Baltimore, MD, 21201.

For subscription or individual issue information, please call 1-800-492-1056 (toll free in MD) or 301-539-0872.

Physician's Practice
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The Pennsylvania Medical Society

April 14-15

Hershey Lodge and Convention
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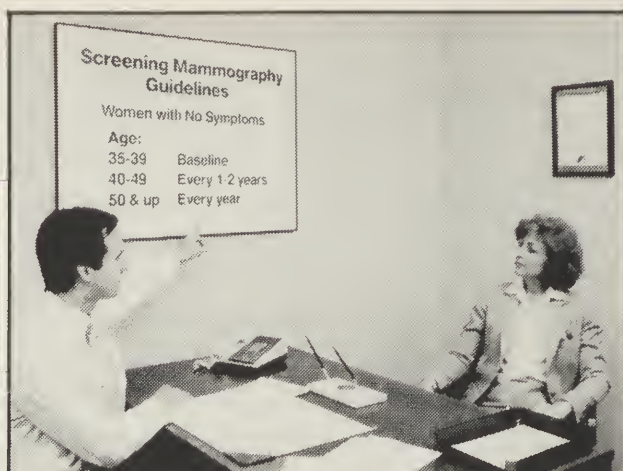
Featuring:

- "Can Quality Medicine Survive in a Managed Care Environment?" with panelists Alice Gosfield, Esq.; Neil Schlackman, MD, Medical Director, U.S. Healthcare; Michael A. Hattwick, MD; David B. Nash, MD, Jefferson Medical College;
- "Health Care: Election '92" with *Newsweek's* Eleanor Clift and *The New Republic's* Fred Barnes;
- "Practical Political Involvement for Physicians";
- A workshop for the future leaders of medicine;
- "Coping with KePRO," with Donald Harrop, MD, President, Keystone Peer Review Organization;
- "Practice Parameters," with Robert E. McAfee, MD, Vice Chairman of the AMA Board of Trustees;
- "Liability Reform," with Lucian Leape, MD, Harvard;
- *Pittsburgh Press* political cartoonist Rob Rogers.

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Miscellaneous meetings

- Perspectives in orthopaedics and sports medicine**, sponsored by the Maryland Academy of Family Physicians, at Wisp Resort, Deep Creek Lake, McHenry, MD. 5 Cat 1 AMA/PRA credits; 5 AAFP prescribed hours. Fee: \$55 MAFP members; \$80 nonmembers; \$35 paramedicals; free for residents, medical students, and MAFP retired and life members. Info: John B. Umhau, Jr., M.D., 410-747-1980. **Mar. 7**
- 32nd annual scientific session and annual meeting of the Maryland Thoracic Society**, at the Baltimore Marriott-Inner Harbor Hotel, Baltimore, MD. 14 Cat 1 AMA/PRA credits. Info: Valerie D. Craig, 410-560-2120. **Mar. 7 – 8**
- The sixth annual review and update course in critical care medicine**, sponsored by the Center for Bio-Medical Communication, Inc., at the Hyatt Regency-Capitol Hill, Washington, DC. 35 Cat 1 AMA/PRA credits. Info: Svetlana Lisanti, 201-385-8080. **Apr. 22 – 26**
- Mini-invasion and megatreatments: Med Chi's 194th annual meeting**, at the Omni Inner Harbor Hotel, Baltimore, MD. Info: Betsy Newman, 410-539-0872 or 1-800-492-1056. **Apr. 30 – May 2**
- The annual meeting of the Virginia Society of Otolaryngology—Head and Neck Surgery**, at the Boar's Head Inn, Charlottesville, VA. Info: Donna Scott, 804-353-2721. **May 1 – 2**
- Trauma is no accident: 92/societal violence—A national epidemic**, sponsored by the American Trauma Society, at the McLean Hilton, McLean, VA. Info: 800-556-7890. **May 6 – 8**
- Rural health: Caring for the country**, sponsored by the National Rural Health Association, at the Hyatt Regency Crystal City Hotel, Washington, DC. Info: Robert Quick, 816-756-3140. **May 6 – 9**
- Clinical auscultation of the heart**, sponsored by the American College of Cardiology, at the Georgetown University Medical Center, Washington, DC. 18 Cat 1 AMA/PRA credits. Info: Registration secretary, 800-257-4739. **May 13 – 15**
- 44th annual meeting and scientific session of the Maryland Academy of Family Physicians**, at the Sheraton Ocean City Resort and Conference Center, Ocean City, MD. 30.75 Cat 1 AMA/PRA credits; 30.75 AAFP prescribed hours. Fee: \$195 MAFP members; \$225 nonmembers; \$110 paramedicals; free for residents, medical students, and MAFP retired and life members. Info: Francis C. Bruno, M.D., 410-747-1980. **May 13 – 17**
- Virginia Society of Ophthalmology annual meeting**, at the Marriott, Richmond, VA. Info: Donna Scott, 804-353-2721. **May 15 – 16**
- Revitalization for emergency professionals and spouses**, sponsored by the Maryland Chapter, American College of Emergency Physicians, at the Morrison House Hotel, Alexandria, VA. Fee: \$175 physicians; \$25 spouses with physician. Info: 410-727-2237. **May 16**
- Interactive healthcare '92 conference and exposition**, sponsored by Stewart Publishing, Inc. and Interactive Health Care Consortium. Info: 703-354-8155. **June 18 – 21**

Shady Grove Adventist Hospital

9901 Medical Center Drive, Rockville, MD. Info: 301-279-6115.

- Sleep disorders.** **Mar. 5**
- Nw aspects of allergic rhinitis.** **Mar. 12**
- Advances and controversies in breast reconstruction.** **Mar. 19**
- Pediatric surgery.** **Mar. 26**
- Advances in management of testicular tumors.** **Apr. 2**
- Risk management.** **Apr. 9**
- Psychosocial aspects of caring for the cancer patient.** **Apr. 23**
- Overview of the new angiography suite at SGAH.** **Apr. 30**

The Johns Hopkins Medical Institutions

All courses at the Turner Auditorium unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Education, 720 Rutland Ave., Baltimore, MD 21205 (410-955-2959).

- 33rd annual postgraduate institute for pathologists in clinical cytopathology** for board certified (or qualified) pathologists as a subspecialty residency. 140 Cat 1 AMA/PRA credits for two courses, both of which must be taken. Preregistration must be completed by March 15, 1992. **Mar. – Apr.**
- Home study, course A.** Personal reading and microscopic study in preparation for Course B. **Mar. – Apr.**
In-residence, course B. Concentrated lecture series with intensive laboratory studies. **Apr. 6 – 17**
- PET and SPECT imaging of living brain chemistry in health and disease.** 19 Cat 1 AMA/PRA credits. Fee: \$495 physicians; \$395 residents. Info: Julia W. Buchanan, 410-955-8582. **Mar. 11 – 13**
- Perspectives on clinical nutrition: Seminar for nutrition practitioners.** Cat 1 AMA/PRA credits available. Fee: \$240 physicians; \$180 allied health professionals. **Mar. 27 – 28**
- 4th Baltimore perinatal colloquium.** 23 Cat 1 AMA/PRA credits; ACOG cognates available. Fee: \$450 physicians; \$250 residents. **Apr. 1 – 4**
- J. Donald Woodruff Symposium on gynecologic oncology,** at the Marriott Inner Harbor Hotel, Baltimore, MD. Cat 1 AMA/PRA credits available. **Apr. 9 – 11**
- Do not resuscitate and beyond: Life and death decision-making.** Cat 1 AMA/PRA credits available. Fee: \$75. **Apr. 13**
- Basic concepts in dysphagia diagnosis and management.** Cat 1 AMA/PRA credits available. Fee: \$125 physicians; \$95 residents and allied health professionals. **Apr. 22**
- 4th multidisciplinary symposium on dysphagia.** Cat 1 AMA/PRA credits available. Fee: \$400 physicians; \$225 residents and allied health professionals. **Apr. 23 – 24**
- Pediatric allergy and immunology for the practitioner.** Cat 1 AMA/PRA credit available. **May 7 – 8**
- The Philip A. Tumulty topics in clinical medicine 1992.** 38 Cat 1 AMA/PRA credits. Fee: \$650 physicians; \$400 residents and allied health professionals. **May 11 – 15**
- The 5th summer institute in environmental health studies.** Info: Dr. Jacqueline Corn or Catherine Walsh, 410-955-2609. **May 18 – 29**

Continuously throughout the year

- Visiting preceptorship in pediatric critical care medicine.** Ongoing five-day preceptorship by appointment. 40 Cat 1 AMA/PRA credits. Fee: \$600.
- Ophthalmic electrophysiology technician training course.** Ongoing one-week course by appointment. The Wilmer Eye Institute, Baltimore, MD.
- Ophthalmology grand rounds.** Audiovisual continuing education series of case discussions for clinicians; 3-8 topics per conference. Thursdays, 7:30-9:00 a.m. 2 Cat 1 AMA/PRA credits per session. Info: 410-955-5700.
- Neuro-ophthalmology conference.** Held twice per month. Info: 410-955-5700.
- Cornea conference.** Held monthly. Info: 410-955-5700.
- The department of radiology and radiological sciences** offers several courses in abdominal and obstetrical ultrasound. Info: P. Williams, 410-955-3169.
- Visiting physicians.** Offered throughout the year for experience in the lab and participation in read-in sessions; by appointment only. 40 Cat 1 AMA/PRA credits. Fee: \$500.
- Johns Hopkins medical grand rounds.** Accredited audiovisual continuing education series of case discussions for clinicians; thirty topics per year in five bimonthly programs. Individual and group subscriptions. 40 Cat 1 AMA/PRA credits. Info: 410-955-3988.
- Microsurgery training at the Johns Hopkins Hospital.** One-week program offered continuously throughout the year. 40 Cat 1 AMA/PRA credits. Info: P. Williams, 410-955-3169.

University of Maryland

For each course, additional information may be obtained by contacting the Program of Continuing Education, University of Maryland School of Medicine, Room 14-011, BRB, 655 W. Baltimore St., Baltimore, MD 21201 (410-328-3956) or by calling the phone number listed after a specific program. FAX 410-328-3103.

Subspecialty care in general pediatric practice, at the University Club, UMAB campus, Baltimore, MD. 1 Cat 1 AMA/PRA credit. Fee: \$50. Info: Richard Ringel, M.D., 410-328-6666. **Mar. 4 & May 5**

R. Adams Cowley 14th national trauma symposium, at the Hyatt Regency, Baltimore, MD. Info: Kimberly C.A. Unitas, 410-328-2399. **Mar. 6 – 8**

Laparoscopic surgery: The team approach. 14 Cat 1 AMA/PRA credits. Fee: \$2,500. Info: Pat Rahmiow, 410-321-5481. **Mar. 27 – 28**

Current cancer therapy symposium. Info: Sharon Stenhouse, 410-328-3956. **Apr. 3**

Power and medical ethics: The Ipolitas Benedict Bronushas lecture, at the R.A. Cowley Shock Trauma Conference Center Auditorium. Info: 410-448-2770. **Apr. 10**

Infectious diseases in everyday medicine: Second annual symposium, at the Baltimore Convention Center, Baltimore, MD. 12 Cat 1 AMA/PRA credits. Fee: Before April 1, \$175 physicians, \$50 residents and students; After April 1, \$200 physicians; \$75 residents and students. Info: Eunice Katz, 410-328-7560. **Apr. 23 – 24**

12th annual Abraham H. Finklestein memorial lecture. Info: Bonnie Winters, 410-328-6777. **May 8**

18th annual family medicine review course, in Ocean City, MD. 25 Cat 1 AMA/PRA credits. Fee: \$395. Info: Sharon Stenhouse, 410-328-3956. **June 21 – 26**

Continuously throughout the year

Visiting professor program - A new 1992 directory of speakers and their topics is available to area hospitals and other health care organizations. NO administrative fees are charged for this service. Info: 410-328-3956.

Departmental rounds and conferences - Weekly, hands-on and lecture presentations hosted by the University's clinical departments. Hour-for-hour Cat 1 AMA/PRA credits available. Brochure available.

Pediatric grand rounds - Every Thursday from September to June, except third Thursday, in the R. Adams Cowley Shock Trauma Auditorium. Info: Bonnie Winters, 410-328-6777.

Physician Placement Services

The Medical and Chirurgical Faculty of Maryland maintains a Placement Service for the convenience of Maryland physicians, hospitals, and communities in search of candidates for positions available in our state. A detailed description of such opportunities should be forwarded to:

Physician Placement Service
1211 Cathedral St., Baltimore, MD 21201-5585
(301-539-0872)

Physicians wishing to locate in Maryland are invited to submit a resume to be kept on file with the Physician Placement Service. Candidates are requested to inform the Faculty when they are no longer available for consideration for opportunities in Maryland.

MMJ announcements on the Classified Advertising page for Physician Placement Service are charged at the regular Classified Advertising rate.

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As a doctor, you can use your first-hand knowledge and experience to make a difference in winning the



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**To volunteer or for more details,
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INTERNIST

Board certified internist seeks board certified/eligible associate for growing general internal medicine practice. Competitive salary, incentive bonus, excellent coverage, paid malpractice, health insurance, and vacation. Beautiful area with excellent schools only 40 minutes from Baltimore. Send CV to Linda Harder, V.P. Marketing, Carroll County General Hospital, 200 Memorial Ave., Westminster, MD 21157.

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Busy 5-person family practice group seeks board-certified/eligible family practitioner to join their Sykesville office. Competitive salary, incentive bonus; excellent coverage arrangements; paid malpractice, health, disability, and vacation, with partnership potential after two years. All members of the practice are board certified. Beautiful area only 30 minutes from Baltimore. Send CV to Linda Harder, V.P. Marketing, Carroll County General Hospital, 200 Memorial Ave., Westminster, MD 21157.

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OBSTETRICS-GYNECOLOGY PRACTICE FOR SALE

Located in the Garwyn Medical Center, Suite 207, 2300 Garrison Blvd., Baltimore, MD 21216 (410-947-0138). Price reasonable.

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Fully established family practice located in residence in vicinity of Hagerstown, MD, near Washington County Hospital. Terms available. Will consider sale of practice separate from real estate. Contact Evan Novenstein 301-279-7000 for details.

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Speak Out on Consultation

Consultation, a radio program sponsored by the Medical and Chirurgical Faculty of Maryland allows Med Chi physicians to appear each week on the program to discuss the latest developments in medicine and to answer questions about health issues. Med Chi currently airs two sessions of Consultation:

Saturday Evening Consultation

A live program

Saturday from 5:00 to 6:00 p.m. and 6:00 to 7:00 p.m.

Broadcast across the country

An hour-long program

Call-in format: Physician answers questions from listeners

Sunday Morning Consultation

A pre-taped program

Sunday at 7:30 a.m.

Broadcast on WBAL - AM radio

A half-hour program

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For more information, contact Lori Robinson at 539-0872 (Baltimore area) or at 1-800-492-1056 (toll-free from elsewhere in Maryland).

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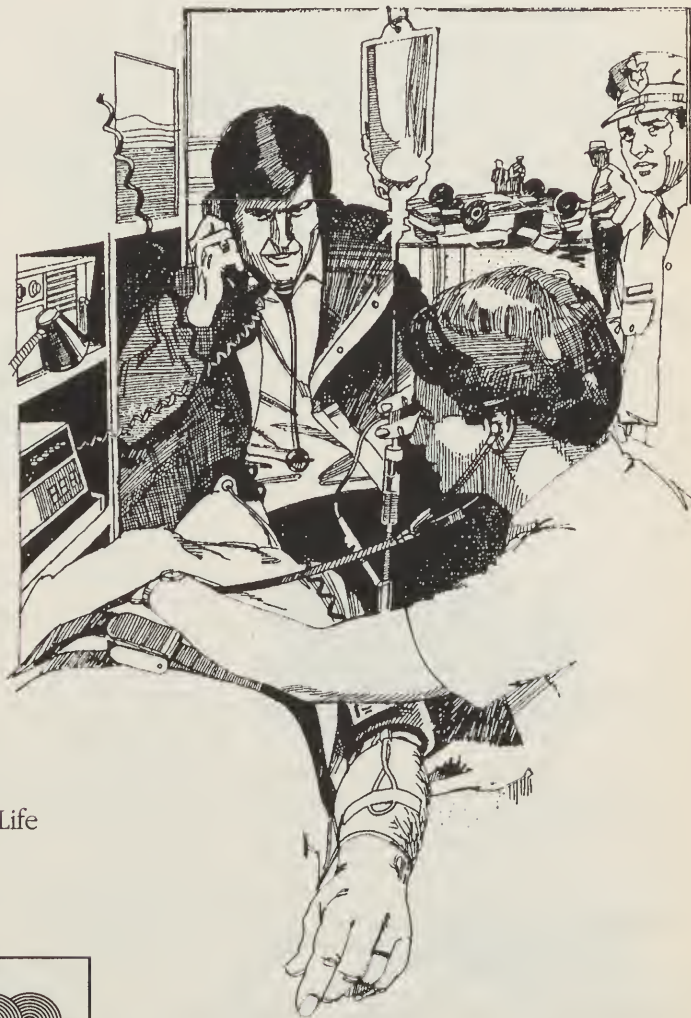
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WHY SHOULD YOU REFER CHILDREN AND ADOLESCENTS WITH SPINA BIFIDA TO CUMBERLAND HOSPITAL?

Cumberland Specializes in Child and Adolescent Care

Each year, some 200 pediatric patients ages 2-22 needing rehabilitation and behavior management are admitted to Cumberland Hospital for Children and Adolescents. While many hospitals provide excellent medical treatment, Cumberland adapts its programs to meet the social and psychological needs of young people.

Treatment is often incorporated into traditional adolescent activities. For example, treatment may include a basketball or volleyball game played in the gymnasium or the swimming pool. Individual mobility goals may be tested and explored during an outing to one of the local parks such as Busch Gardens (amusement park), Jamestown, Yorktown or Williamsburg.

For the young person with spina bifida, there is always a new challenge and a new opportunity to stretch his or her abilities and confidence.

Functional Mobility and Independence

The most visible and often most emotionally charged issue for the young person with spina bifida is mobility. Almost all children with spina bifida wear orthoses, and many use wheelchairs. Ambulatory skills are often achieved late and tend to reach a maximum in the 5- to 8-year-old age group.

With the approach of adolescence, there are increases in weight and height that make ambulation more difficult and less cosmetic.



Difficult decisions must be made regarding the young person's future. Cumberland assists patients and their parents in determining the form of mobility that is most acceptable to them, and help them structure their lives accordingly.

Adolescence is also a time when all young people begin to become independent, and independence for the young person with spina bifida means they take responsibility for their bowel and bladder program and for donning and doffing their braces.

Cumberland evaluates the gross and fine motor skills of the patients as well as their level of intellectual functioning. This information is needed to assist patients and their parents in setting reasonable expectations. Behavior and therapy programs are structured around these expectations.

Cumberland Is A Hospital

Cumberland is licensed by the Commonwealth of Virginia and accredited by the Joint Commission on Accreditation of Healthcare Organizations. It is one of only a few hospitals in the United States where all the physicians on the admitting staff are Board Certified in their specialty.



Cumberland Doesn't Look Like a Hospital

The hospital looks more like a small college with buildings connected by sidewalks, and picnic tables and recreation facilities are disbursed among the facilities. It is common to see young people in small groups talking, studying or listening to music. Throughout the day, they go between the dormitory, cafeteria, rehabilitation, school and other buildings.

Depending on their level of physical abilities and behavior program, the young people are given levels of independence on the campus ranging from strict one-on-one staff supervision to free movement within the immediate environment.

Young People At Cumberland Go To School

One of the most important elements in the life of a young person is school, and at Cumberland patients go to school. Integrated into the hospital campus is Cumberland Academy—a licensed private school. The building includes classrooms, a library, prevocational department and gymnasium.

Course work is obtained from each patient's home school and classes are conducted around treatment and rehabilitation programs.

Cumberland Serves Many Different Young People

Cumberland provides treatment for young people with many types of medical and behavioral problems, and this has proved to be very beneficial for the patients with spina bifida. While there are usually a number of young people in the hospital with spina bifida, there are also patients with brain injury, diabetes, seizure disorders, spinal cord injuries, asthma and other conditions.

The young people quickly develop friendships and learn about the "disabilities and abilities" of the other young people. They leave the hospital with their medical needs treated and better able to cope with problems and challenges they encounter.

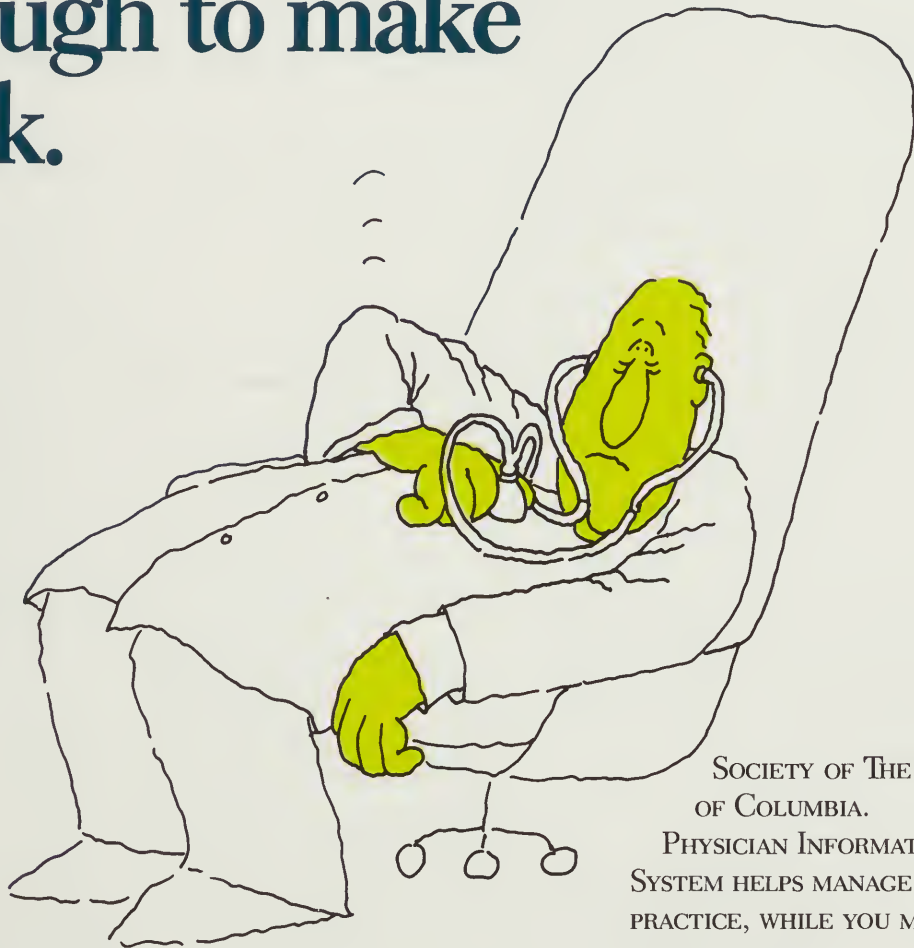
Cumberland's Setting

Cumberland is located on the Pamunkey River and is part of 1,200 acres owned by the hospital. There are three large lakes on the property for fishing and boating, and miles of trails.

For more information on Cumberland Hospital or to refer a patient for treatment, please call the information office at 1-800-368-3472.

**Cumberland Hospital
for Children and Adolescents**
New Kent, Virginia

Competition, HMOs, Insurance and slow-paying patients... it's enough to make you sick.



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- Hospital-based professional assistance committees
- Patterns of substance use in the medical profession
- Follow-up studies:
 - Maryland, Georgia, District of Columbia, New Jersey



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Adolescence is also a time when all young people begin to become independent, and independence for the young person with spina bifida means they take responsibility for their bowel and bladder program and for donning and doffing their braces.

Cumberland evaluates the gross and fine motor skills of the patients as well as their level of intellectual functioning. This information is needed to assist patients and their parents in setting reasonable expectations. Behavior and therapy programs are structured around these expectations.

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Cumberland is licensed by the Commonwealth of Virginia and accredited by the Joint Commission on Accreditation of Healthcare Organizations. It is one of only a few hospitals in the United States where all the physicians on the admitting staff are Board Certified in their specialty.



Cumberland Doesn't Look Like a Hospital

The hospital looks more like a small college with buildings connected by sidewalks, and picnic tables and recreation facilities are disbursed among the facilities. It is common to see young people in small groups talking, studying or listening to music. Throughout the day, they go between the dormitory, cafeteria, rehabilitation, school and other buildings.

Depending on their level of physical abilities and behavior program, the young people are given levels of independence on the campus ranging from strict one-on-one staff supervision to free movement within the immediate environment.

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One of the most important elements in the life of a young person is school, and at Cumberland patients go to school. Integrated into the hospital campus is Cumberland Academy—a licensed private school. The building includes classrooms, a library, prevocational department and gymnasium.

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Cumberland Serves Many Different Young People

Cumberland provides treatment for young people with many types of medical and behavioral problems, and this has proved to be very beneficial for the patients with spina bifida. While there are usually a number of young people in the hospital with spina bifida, there are also patients with brain injury, diabetes, seizure disorders, spinal cord injuries, asthma and other conditions.

The young people quickly develop friendships and learn about the "disabilities and abilities" of the other young people. They leave the hospital with their medical needs treated and better able to cope with problems and challenges they encounter.

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National drug use surveys of medical students and resident physicians in 1987 found that medical school was not a time when students began to use drugs, nor was it a time when they engaged in heavy use. Medical students and resident physicians reported lower rates of illicit drug use than their age and gender counterparts. Although males generally were more likely to use substances than females, young male and female physicians resembled one another in their current rates of substance use more than they resembled their gender counterparts in society.
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Nine years experience with chemically dependent physicians:

The New Jersey experience 325

Edward G. Reading, M.Div., NCAC II

Few studies have been able to retroactively evaluate the effectiveness of treating chemically dependent physicians. This paper provides an overview of the Physicians' Health Program of the Medical Society of New Jersey; details the current status of physicians treated for chemical dependency from 1982 to 1990; lists the perceived reasons for successful recovery; and identifies the needs for the future.

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Cover: The Maryland Physician Rehabilitation Committee logo featured in the background represents a sun rising behind a mountain with a helping hand beneath. The sunrise symbolizes the beginning of a new day, the mountain represents the arduous journey, and the hand signifies the Physician Rehabilitation Program.

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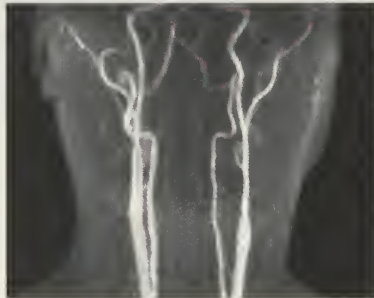
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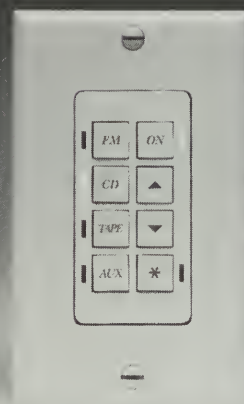
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Physician rehabilitation: Is it science?

An unstable nervous system is the fundamental basis on which habitual alcoholic excesses develop. There is the weakness of will, the tendency to over-indulge, the lack of self-control, and when once the narcotic effect of alcohol is felt, the inevitable craving for more cannot be resisted. In these weak individuals there is often the marked self-conceit which deludes them into the belief that they can resist when they wish.

(Alexander Lambert, M.D. In: William Osler, ed. *Modern Medicine* 1907; 1: 57.)

Physician impairment is a popular topic. Everyone wants to read about fallen idols. If the morning paper reports a scandal in polarizing rhetoric or if the Board of Physician Quality Assurance (BPQA) reports its proceedings in legalese, it is tempting to read between the lines. How could someone let that happen? Surely the impairment must result in pain, in shame, and in financial ruin. The someones are colleagues. They have survived the rigors of medical school, have memorized obscure data, have stayed up all night on a hospital ward, and have treated our patients. They are us.

Chronic alcoholism is a condition very difficult to treat and once fully established, the habit is rarely abandoned. The most obstinate cases are those with marked hereditary tendency.

(William Osler, M.D. *The Principles and Practice of Medicine* 1899; 383.)

The articles in this issue concern the remedy for impairment and the prevention of public embarrassment. They also result in a peculiar editorial ambivalence.

On the one hand, the theme is vital, current—the information should be received by all physicians. Rehabilitation might even overtake impairment as a readable topic. The *MMJ* editorial board wants the readers provided with current data.

On the other hand, the same board is skeptical about the scientific procedures described in the papers. Here, in a medical journal, you are reading about some ambitious clinical efforts but the facts, figures, and conclusions are not "hard" data. Some are very soft indeed.

The condition is one which has become so common, and is so much on the increase, that physicians should exercise the utmost caution in prescribing morphia, especially to female patients. Under no circumstances whatever should a patient with neuralgia or sciatica be allowed to use the hypodermic

syringe, and it is even safer not to intrust this dangerous instrument to the hands of a nurse.

(William Osler, M.D. *The Principles and Practice of Medicine* 1899; 386.)

In "Patterns of substance use in the medical profession," Hughes et al present some limited conclusions from a pilot survey in which approximately 40 percent of the participants "returned usable questionnaires."

Meek provides a concise overview of his committee's work in the District of Columbia. He does not try to explain the reasons for the 80 percent success rate.

The article on New Jersey's experience describes similar outcome percentages but goes another step to explain the success rate. Using such concepts as "personal relationship" and "tightening-up of the recovery plan," Reading provides a glimpse of the procedures but no way to grasp the mechanism of action.

Describing Georgia's experience, Gallegos et al give more details on the concept of relapse. The overall success rate is similar to other groups and it is heartening. Attempts to explain treatment failures include "more likely to not believe the disease concept" and "emotional issues that seemed to trigger the relapse behavior." Successes include those who "gladly use their monitoring physician," the use of "re-people-ization," and "spiritual program...an absolutely essential ingredient of recovery."

If it is disturbing that so many of these articles encourage "true belief" in some murky concepts, it should not curb enthusiasm for the honest effort on behalf of rehabilitation.

Perhaps the skepticism will prompt a healthy search for even better, more efficient, more measurable, and more scientific treatments.

In the alcoholic days, I had not been able to answer the question as to why I drank. In this adjustment period, I occasionally asked myself why I did not drink and I was equally unable to answer the question. Conscious decision not to drink was no more a part of this thinking than conscious decision to drink had been a part of the former pattern.

(Roy Washington, M.D. [pseudonym]. *Chronic alcoholism*. In: Pinner M, Miller B, eds. *When Doctors are Patients*. New York: Norton. 1952; 152.)

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Spironolactone for the treatment of PMS

I read with great interest the article by Dr. Backerman on premenstrual tension syndrome that appeared in the November 1991 *Maryland Medical Journal*. I certainly concur with Dr. Backerman that benzodiazepines should not be utilized for the treatment of this disorder, due to the potential for the creation of depression, memory loss, and interference with natural sleep, as well as their addictive potential.^{1,2} However, the recommended treatment, Buspirone, has some side effects that should be mentioned. Notably, Buspirone does produce tardive dyskinesia, which may create long-term, if not irreversible, movement of the mouth. Also, Dr. Backerman neglects to mention the use of spironolactone, a drug which I first reported effective almost currently with a report appearing in the English literature.³ In a commentary appearing in *JAMA*, it was reported that spironolactone was the only drug proven efficacious, in double-blind crossover trials, for controlling the symptoms of premenstrual tension syndrome.⁴ However, premenstrual tension syndrome seems to be multifactorial, and there is probably no single pharmacological agent that will treat all of the symptoms of the disorder. However, Dr. Backerman is to be commended for his efforts in delineating the etiology of premenstrual tension syndrome.

NELSON HENDLER, M.D., M.S.
Stevenson, Maryland

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4. Commentary. *JAMA* September 16, 1983.

The use of Buspirone in treating PMS

I am replying to Dr. Nelson Hendler's letter regarding my recent article on PMS in the *MMJ* (November 1991).

Buspirone was originally given to patients who were precipitously taken off of neuroleptic drugs and developed tardive dyskinesia. It has been shown that the occurrence of tardive dyskinesia is *not* related to Buspirone; in fact, Dr. Vernon Nepe, in his excellent textbook, *Innovative Psychopharmacotherapy*, has postulated that higher doses of Buspirone may be quite useful in the treatment of tardive dyskinesia.

Dr. Hendler's letter also mentions the use of spironolactone in PMS, and I am aware of his work with spironolactone; however, on page 1007 of my article, I acknowledge spironolactone as one more pharmacologic approach to PMS management.

I do agree with Dr. Hendler and many experts in pharmacology, endocrinology, and psychiatry that many approaches have been tried in PMS managements. I still insist that Buspirone is safe and quite effective for the emotional components of PMS, especially anxiety, anger, and hostility.

IVAN A. BACKERMAN, M.D.
Atlanta, Georgia

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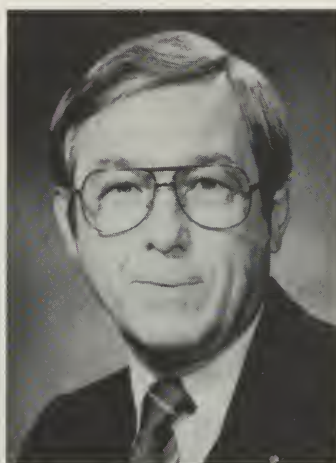


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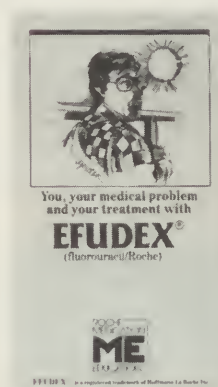
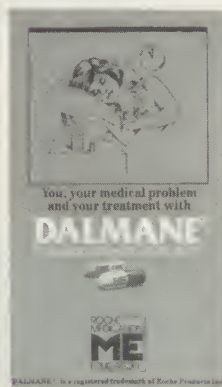
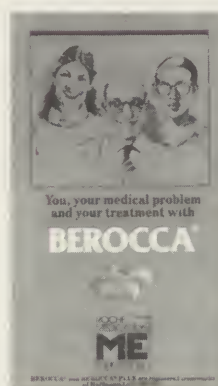
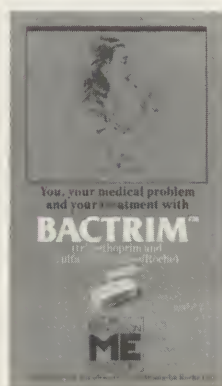


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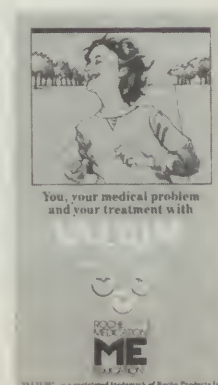
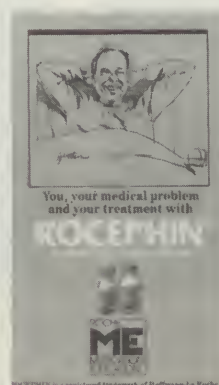
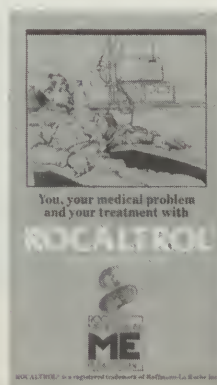
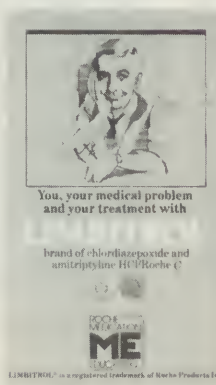
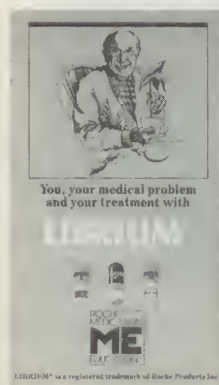


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The magnificent hoax

Bart Gershen, M.D.

In ancient Greece, cosmologists believed that matter was composed of four fundamental elements: earth, air, fire, and water. This left nothing to explain the nature of one's spiritual self, that God-searching, introspective philosopher within us all (exempting politicians).

Something else was clearly needed to satisfy that meta-physical requirement—the purest form of matter, fashioned from divine material. The cognoscenti selected **ether**, the imaginary material from which the heavens were thought to derive. The Greeks called this divine substance *pempte ousia*. The Romans simply called it *quinta essentia* the 'fifth essence'. And so they delivered to our modern world the **quintessence** of everything perfect.

Early physicians tried to explain illness in a similar manner. They envisioned the human as a receptacle containing four liquid substances (*humors*, Latin meaning moisture or fluid), each of which dictated a pattern of behavior. Balanced properly, the human remained well. However, an imbalance of these liquids led quickly to illness (one would be "out of humor"). There were four such humoral substances: blood, phlegm, yellow bile, and black bile.

An excess of blood would cause a person to be red-faced, warm, passionate, cheerful—in effect, **sanguine** (Latin *sanguineus* 'blood'). A surplus of phlegm resulted in a taciturn, cold, aloof, reserved personality. In short, one would be **phlegmatic**. An excess of yellow bile caused one to be bitter, sarcastic, hostile—in other words, to have a **bilious** personality and to assume a **jaundiced** view of the world. Lastly, a glut of black bile would result in depression, despair, and gloom. One would manifest **melancholy** (Greek *melanos* 'black' + *chole* 'bile').

From the sixteenth through the eighteenth centuries, English comedies often relied heavily on such eccentric caricatures to goad audiences into roars of laughter, prompting critics to call these plays **humorous**.

Something which cannot be called humorous, however, is the issue of scientific fraud. Unfortunately, within the past several years our profession has witnessed several disquieting instances of this behavior. One need only recall the case of John Darsee of Harvard Medical School, whose fabricated experiments resulted in his dismissal, followed by apologetic retractions from his distinguished superiors.

Yet scientific fraud has not been confined to the modern world. The greatest astronomer of ancient times—Claudius Ptolemy—did not make the planetary observations specified in his original data. He appears to have borrowed them entirely from the work of Hipparchus of Rhodes, an earlier astronomer. And instances of apparent deception have been imputed to such scientific luminaries as Galileo Galilei, Gregor Mendel, John Dalton, and Robert Millikan, the American Nobel-prizewinning physicist.

Perhaps the greatest scientific swindle of all time, however, took place at the beginning of this century. It involved a lawyer, anthropologist, and physician whose name may be familiar to you in quite a different context.

In 1856, workers discovered the skeletal remains of a human in the Feldhofer Cave located seven miles east of Düsseldorf, Germany. The skull was smaller than average for an adult, and there were prominent supraorbital ridges and coarse cheek bones. Arguments mushroomed over the nature of this find. Broca believed the anatomy was that of an earlier species of man. Virchow disagreed. But it was finally established that the skeleton was an early specimen of *Homo sapiens*. It was roughly one hundred thousand years old.

The cave itself was located near a stream in the Neander Valley. Therefore, the fossil was called **Neanderthal man**. (German *thal* 'valley'. The word is cognate with our term **dale**. In Czechoslovakia, there is a valley named for St. Joseph, **Joachimsthal**, that had become the location for a mint in the sixteenth century. A coin issued there was known as a **Joachimsthaler**, ultimately shortened to a **thaler**, and finally a **taler**. The Dutch called it a **daler**, and we refer to it as a **dollar**. Today, one needs a valley full of them to buy anything.)

Shortly after the discovery of *Homo sapiens Neanderthalis*, other skeletal finds were made in France, Italy, China, Africa, and on the island of Java. Marie Eugene François Thomas Dubois, a physician and lecturer in anatomy at the University of Amsterdam, was impassioned over the idea that earlier forms of man (**hominids**) might be discovered in caves, gravel beds, and rock strata, awaiting the probing eyes and hands of some fortunate paleontologist. He accordingly journeyed to the East Indies as a military surgeon. Once there, he began his explorations on the island of Sumatra.

In 1890, on the island of Java, Dubois discovered a skull fragment, jaw bone, and thigh. He believed them to represent the missing link between apes and hominids—the ape-man, *Pithecanthropus* (Greek *pithekos* 'ape' + *anthropos* 'man'), much better known to the world as the famous **Java man**. Sometime later, in the Chou-k'ou-tien cave near Beijing, China, several additional skulls, mandibles, and limbs were found that matched those of Java man. These quickly became designated **Peking man**. Soon it became clear that none of these bones represented the postulated ape-man. Rather, they were all remnants of an earlier hominid species, now known as *Homo erectus*.

We come then to the celebrated English hoax—perhaps the greatest scientific fraud ever committed. Near the end of the nineteenth century, a rather obscure country solicitor lived and practiced law in County Sussex, England. He was a quiet and rather unpretentious man whose practice was quite modest and whose reputation was quite unassuming.

However, he did enjoy one rather interesting diversion. He was an amateur geologist and anthropologist, a fossil hunter. In fact, he had discovered the first Mesozoic animal in England, had reported it to the proper scientific societies, and had received appropriate commendation. The lawyer's name was Charles Dawson.

He became friendly with a professional scientist, Arthur Smith Woodward, who headed the Department of Geology and Natural History at the British Museum. Dawson was profoundly convinced that specimens of primitive man would eventually be unearthed in England. (Until that time, none had been found there, although monthly reports of such discoveries poured in from virtually every uncivilized country in the world.) Dawson tried to convince Woodward that England—that paradigm of intellectual excellence, the ground which spawned William Shakespeare and Isaac Newton—must ultimately prove to have been the nest of early man.

In 1898, Dawson became legal steward of Barkham Manor, located in the small village of Piltdown. He discovered a large open gravel pit nearby—just the type which he believed might harbor the elusive skeletal finds he so desperately wished to locate.

In 1908, Dawson and a man named Samuel Allinson Woodhead, the local high school chemistry teacher, began an intensive search of those gravel beds. Dawson was later joined by two Jesuit priests who were also nonprofessional, neophyte paleontologists. (One of these, Father Pierre Teilhard de Chardin, was to attain a measure of international stature for his theological, philosophical, and paleontological theories. He, in fact, was one of those who discovered **Peking man**.)

In July 1912, Dawson disclosed to Arthur Woodward that he had found a very primitive human skull and a mandible that he believed might represent the Holy Grail of anthropologists—the missing ape-man link.

On December 18, 1912 at a meeting of the Geologic Society of London, this electrifying discovery was broadcast to the world. The bones were dark brown in color, mute testimony to their prehistoric age. Arthur Woodward and his associate Frank Barlow immediately began the task of reconstructing the face of this ancient ancestor, the common denominator between us and our nearest mammalian relatives.

Someone suggested that a professional anatomist might be useful in accomplishing this goal. (Woodward was, after all, a geologist, not a biologist.) It was quickly decided that the consummate choice would be the conservator of the Hunterian Museum at the Royal College of Surgeons.

This gentleman was a physician graduate of the University of Aberdeen, previously chairman of the Department of Anatomy at London Hospital, and winner of the esteemed Strotter's Prize for his elegant demonstration of the difference between the ligaments of men and apes. He had written extensively about the anatomy of the human heart with Sir James MacKenzie, and had studied with the famous anatomist Wilhelm His. In 1902, he had written the definitive text,

Human Embryology and Morphology. In addition, he had authored *An Introduction to the Study of Anthropoid Apes* (1897), *Ancient Types of Man* (1911), and *The Antiquity of Man* (1915). From 1914 to 1917, he was president of the Royal Anthropologic Institute, and for twenty-three years had been the editor of *The Journal of Anatomy*. For the coup de grâce, he was a member of the Royal Society, president of the British Association for the Advancement of Science, and in 1921, was knighted by King George V. He was, in short, a reasonable choice to analyze the Dawson specimens and to determine their relationship to men and apes.

His conclusions were reached after exacting and meticulous reconstruction of the mahogany-colored bones. The skull cap was clearly hominoid, the jaw with its worn down teeth, obviously ape-like. Yes, these skeletal fragments did indeed represent the long-pursued common ancestor of apes and men—the dawn man.

They named it *Eoanthropus dawsoni*. (Greek *eos* 'dawn' + *anthropus* 'man'). The history of man had just been reshuffled. A new player had cast the die. And Charles Dawson beamed with satisfaction; it was the culmination of his dream.

Except...except...for the doubts. Even from the beginning, a few soft voices murmured uncertainly. Then, in 1924, Raymond Arthur Dart, a surgeon and anthropologist, discovered the famous Taungs skull that had been blasted out of limestone rock by miners in Africa near a small village at the edge of the Kalahari Desert. He named it *Australopithecus africanus* (Latin *Austral* 'southern' + Greek *pithekos* 'ape'). (The name Taungs comes from the name of the nearest railroad station serving the village.) Unexpectedly, Piltdown man had become chronologically anomalous.

Stronger evidence emerged in 1953 when Kenneth Oakley, a geologist from the British Museum, analyzed the brownish pigment discoloring the Piltdown bones. It was found to be potassium dichromate, a chemical that had been deliberately used to stain the fossil bones in order to make them appear much older than they were.

The final confirmation of the stupendous deception was rendered in 1959. Carbon-14 dating proved that the ages of Piltdown's cranial vault and his jaw were millions of years apart. The jaw was authenticated as that of a fossil orangutan. The skull was that of a modern man, possibly an Aborigine, that had been stolen years before from the British Museum.

Oh, yes. What about the celebrated anatomist, anthropologist, and physician who had declared Piltdown to be legitimate? His name was Arthur Keith and with his student, Martin Flack, had been first to describe the Sinoatrial node of the human heart (*Lancet* 2: 359, 1906), the Node of Keith and Flack.

Had Keith been a party to the magnificent deception? Almost certainly not. The best one can say—without expressing too jaundiced or melancholy a view—is that despite impeccable credentials, Sir Arthur had made a remarkable and rather inexplicable error, one that almost validated the quintessential scientific hoax of the twentieth century. ■

INFORMATION FOR AUTHORS INFO

Manuscripts may be sent to Editor, *MMJ*, 1211 Cathedral St., Baltimore, MD 21201-5585. Articles are accepted for publication on the condition that they are contributed solely to this journal. Transmittal letters should designate one author as correspondent and include his/her address and telephone number. Manuscripts are reviewed by editorial board members and guest reviewers.

Specifications

Manuscripts must be original typed copy, double-spaced throughout (including text, case reports, legends, tables, and references), with pages numbered consecutively. Along with manuscripts, please send an IBM-compatible floppy disk, with the document entered in a WordPerfect or ASCII format.

Include full name of author(s) with highest degrees and academic or professional titles.

Tables with brief descriptive titles are to be typed on separate sheets of paper and numbered. The Editor reserves the right to edit tables. Statistics must be consistent in both tables and text.

An introductory synopsis of approximately twenty-five to fifty words is required.

References are limited to those citations noted in the text and are to be typed double-spaced and numbered consecutively as they appear in the text. The number of references generally is limited to twenty in major contributions and fewer in shorter articles. Personal communications and unpublished data should not be included.

Photographic material must be submitted as high-contrast glossy prints. Drawings and graphs must be of professional quality. Recognizable photos of patients are to be masked and should carry with them written permission for publication.

For more extensive information about preparing medical articles for publication, see *Uniform Requirements for Manuscripts Submitted to Biomedical Journals* compiled by the International Committee on Medical Journal Editors (available through the *Annals of Internal Medicine*).

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Medical and Chirurgical Faculty of Maryland's 194th Annual Meeting

Annual Meeting

mini-invasion & MEGATREATMENTS

"Mini-invasion and Megatreatments,"

at the

Omni Inner Harbor Hotel

101 West Fayette Street

Baltimore, Maryland

Thursday – Saturday

April 30, May 1 – 2, 1992

This year's meeting focuses on two exciting new medical technologies:

mini-invasion – the use of "scopes" in surgical and non-surgical diagnosis and treatment; and...

megatreatments – massive treatments administered to reverse negative pathology.



MEETING REGISTRATION AND SOCIAL EVENT RESERVATIONS

Meeting Registration

Med Chi Members

☐ No Charge

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☐ Preregistered nonmembers –
\$25.00/presentation hour*

\$25.00 x _____ hours = _____

(indicate number of presentation hours)

*includes both CME & non-CME courses

☐ On-site registration fee for nonmembers – \$15.00
(access limited to exhibit hall only)

total \$25/presentation \$25 x _____ presentation

\$40/mini-symposium \$40 x _____ mini-symposiums

\$ _____

\$ _____

Event Reservations

Event

Member cost

Nonmember cost

☐ Prayer Breakfast,

Friday, May 1, 1992, 7:00 a.m.

\$7.00 (price/person)

_____ # tickets

\$10.00 (price/person)

_____ # tickets

\$ _____

☐ Workshop and Luncheon

"Your Financial Life Cycle: How to Get it, How to Keep
it and How to Spend it"

Thursday April 30, 1992 12:00 noon

(reservations required, space is limited
to the first 50 physician registrants.)

No Charge

No Charge

☐ Harbor Cruise

(Reservations required, space is limited)

Thursday, April 30, 1992 6:00 p.m. – 9:30 p.m.

(limit 2 tickets)

No Charge

_____ # tickets

\$35.00 (price/person)

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☐ Baseball (Reservations required, space is limited)

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Friday, May 1, 1992 7:35 p.m.

(limit 4 tickets)

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☐ Presidential Banquet

Saturday, May 2, 1992, 7:00 p.m.

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If using your credit card, you may FAX your registration to 410-547-0915 or phone in your registration to Lori Robinson or Vivian Smith at
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For questions about the Omni Inner Harbor Hotel or other events at the annual meeting contact
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Support Our Exhibitors

Exhibits are an integral part of Med Chi's annual meeting and are a valuable adjunct to the scientific program.

By visiting the exhibits before and after your scientific program, you will help ensure that Med Chi continues to receive valuable income that allows us to offer you annual and semiannual meetings.

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Exhibits will be open:

Thursday: 12:00 noon to 5:30 p.m.

Friday: 9:00 a.m. to 5:30 p.m.

Saturday: 9:00 a.m. to 12:00 noon

Exhibitor sweepstakes drawings will occur in the exhibit area on:

Thursday: 2:45 p.m.

Friday: 10:45 a.m.

Saturday: 10:45 a.m.

You must be present to win

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The Medical and Chirurgical Faculty of Maryland designates this continuing medical education activity for 36.5 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association. Physicians attending this year's meeting can earn up to a maximum of 17.5 CME credits.

For questions about continuing medical education credits or any of the scientific sessions call:

Joan Mannion

Director of Continuing Medical Education,
at 1-800-492-1056 or 410-539-0872.

Meeting Overview*

Thursday, April 30, 1992

8:00 a.m. – 5:00 p.m. – Registration

8:30 a.m. – Council Meeting

9:30 a.m. – House of Delegates Meeting/General Membership Meeting featuring:

Special Guest Speaker

Ron Shapiro, Esq.

9:30 a.m. – Spouse Program

11:00 a.m. – 4:00 p.m. – Auxiliary 43rd Annual Meeting

11:30 – Scientific Session

12:00 noon – 12:30 p.m. – Break – Visit the Exhibits –

12:30 p.m. – 1:30 p.m. – Lunch on your own

1:30 p.m. – 2:30 p.m. – Plenary Session

"Health Care Reform"

AMA Trustee Thomas R. Reardon, M.D.

2:30 p.m. – 3:00 p.m. – Break – Visit the Exhibits – Exhibitor Sweepstakes Drawing

3:00 p.m. – 6:00 p.m. – Scientific Sessions

4:15 p.m. – Workshop

"Avoiding Excess Retirement and Estate Taxes: Strategies for the 90s"

Med Chi Agency

6:00 p.m. – 9:30 p.m. – Harbor Cruise aboard the Lady Baltimore (Reservations required – space is limited)

Friday, May 1, 1992

7:00 a.m. – Prayer Breakfast

8:00 a.m. – 5:00 p.m. – Registration

8:30 a.m. – 4:00 p.m. – Auxiliary 43rd Annual Meeting

8:30 a.m. – 6:00 p.m. – Scientific Sessions

8:30 a.m. – Workshop

"Accreditation for Continuing Medical Education"

10:30 a.m. – Break – Visit the Exhibits –

Exhibitor Sweepstakes Drawing

12:00 noon – Auxiliary Meeting and Auction

12:30 p.m. – 1:30 p.m. – Lunch on your own

1:30 p.m. – Mini-Symposium

"Physician Office Labs: Master or Slave?"

4:00 p.m. – Workshop

"Computers in the Medical Office"

7:35 p.m. – Baltimore Orioles vs. Seattle Mariners at the new Oriole Park at Camden Yards (Reservations required – space is limited)

Saturday, May 2, 1992

8:00 a.m. – 12:00 noon – Registration

8:30 a.m. – Mini-Symposium

"Ethics of Dying"

8:30 a.m. – 1:00 p.m. – Scientific Sessions

10:30 a.m. – 11:00 a.m. – Break – Visit the Exhibits – Exhibitor Sweepstakes Drawing

11:00 a.m. – Spouse Program

12:30 p.m. – 1:30 p.m. – Lunch on your own

2:00 p.m. – House of Delegates Meeting

3:00 p.m. – Council Meeting

7:00 p.m. – Presidential Banquet

Honoring Med Chi President J. David Nagel, M.D.
(Reservations required – black tie optional)

Medical and Chirurgical Faculty of Maryland's 194th Meeting Mini-invasion and Megatreatments

at the Omni Inner Harbor Hotel
101 West Fayette Street, Baltimore, Maryland
Thursday – Saturday, April 30, May 1 – 2, 1992

Preliminary Schedule

THURSDAY, APRIL 30, 1992

8:00 a.m. – 5:00 p.m. – Registration

8:30 a.m. – Council Meeting

9:30 a.m. – House of Delegates Meeting

Special Guest Speaker

"Successful Negotiation and Communication"
Ron Shapiro, Esq.

9:30 a.m. – Spouse Program

"Personal Safety and Self-Defense for the 90s"
presented by Citizens Against Crime

11:00 a.m. – 4:00 p.m. Auxiliary 43rd Annual Meeting

11:30 a.m. – *"Current Guidelines for the Diagnosis and Treatment of Bronchial Asthma"*
Maryland Asthma and Allergy Society
CME Credits: 1.5

12:00 noon – 12:30 p.m. – Break – Visit the Exhibits

12:00 noon – Workshop

"Your Financial Lifecycle: How to Get it, How to Keep it and How to Spend it"
Steven Weisman, C.P.A.
CME Credits: None
(Reservations required for this workshop and luncheon – space is limited.)

12:30 p.m. – 1:30 p.m. – Lunch on your own

1:30 p.m. – 2:30 p.m. – Plenary Session

"Health Care Reform"
AMA Trustee Thomas R. Reardon, M.D.

2:30 p.m. – 3:00 p.m. – Break – Visit the Exhibits
Exhibitor Sweepstakes Drawing

3:00 p.m. – Scientific Sessions

"Primary Care Follow-up of the Cancer Patient"
Maryland Academy of Family Physicians
CME Credits: 1.5

"Efficacy vs Expense: Maximizing Drug Therapy Outcomes in Your Patient"
Med Chi Committee on Therapeutic Education
CME Credits: 2

"A Fifteen-Year Overview of Focused Remedial Education: A Look at its Present and Future"

Med Chi Committee on Focused Professional Education
CME Credits: 1

4:00 p.m. – Workshop

"Effective Pension Plan Management"
The Prudent Investor's Workshops
CME Credits: None
(cocktail hour to follow this workshop)

4:15 pm – Workshop

"Avoiding Excess Retirement and Estate Taxes: Strategies for the 90s"
Med Chi Agency
CME Credits: None

4:30 p.m. – Scientific Sessions

"The Breast Implant Controversy"
The John Staige Davis Society of Plastic Surgeons of Maryland
CME Credits: 1
"Endoscopy in Gynecology"
Infertility Associates
CME Credits: 1

6:00 p.m. – 9:30 p.m. – Harbor Cruise aboard the
Lady Baltimore
featuring dinner buffet & dancing
(Reservations required - space is limited)

FRIDAY, MAY 1, 1992

7:00 a.m. – Prayer Breakfast

"The Physician's Responsibility to Notify the Patient: Duty and Morality"
Med Chi Committee on Medicine and Religion
CME Credits: 1

8:00 a.m. – 5:00 p.m. – Registration

8:30 a.m. – 4:00 p.m. – Auxiliary 43rd Annual Meeting

8:30 a.m. – Scientific Sessions

"Claims Abstracts: Learning From Experience"
Medical Mutual Liability Insurance Society of Maryland
CME Credits: 2
Fee of \$40.00 required for this course. Register at door.
"Innovative Strategies for Risk Management"
American Heart Association – Maryland Chapter
CME Credits: 2

8:30 a.m. – Workshop

"Accreditation for Continuing Medical Education"

Med Chi Continuing Medical Education Review Committee
(invitational workshop for CME directors/staff)
CME Credits: None

9:30 am – Workshop

"Delegated Self Review: A Physician-Oriented Solution to Cost and Quality Problems"

Maryland Foundation for Healthy Policy Research
CME Credits: None

10:30 a.m. – 11:00 a.m. – Break – Visit the Exhibits – Exhibitor Sweepstakes Drawing

11:00 a.m. – Scientific Sessions

"Megatrends in Dermatology"

Maryland Dermatological Society, Inc.
CME Credits: 1.5

"Assessment and Care of the Alcohol-Using Patient"

Med Chi Committee on Alcoholism and Chemical Dependency
CME Credits: 1

"Children and Youths as Performing Artists: Protection of Hearing and Vision"

Med Chi Committee on Medicine and the Performing Arts
CME Credits: 1

"The Battered Women Syndrome – The Hidden Trauma"

Maryland Psychiatric Society Women's Committee in cooperation with the Med Chi Women in Medicine Committee
CME Credits: 2

12:00 noon – Auxiliary Meeting and Auction

12:30 p.m. – 1:30 p.m. – Lunch on your own

1:30 p.m. – Mini-Symposium

"Physician Office Labs: Master or Slave?"

Med Chi Ad Hoc Committee on Laboratory Regulations
CME Credits: 2

3:30 p.m. – Workshop

"Computers in the Medical Office"

Med Chi Committee on Computers in Medicine
CME Credits: None

4:00 p.m. – Scientific Sessions

"Caring for the HIV-Positive Patient"

Med Chi Committee on AIDS
CME Credits: 2

"Detection and Office Management of Patients with Eating Disorders"

Governor's Task Force on Eating Disorders
CME Credits: 1

"Physicians and the Media"

Med Chi Public Relations Committee
CME Credits: 1

"Substance Abuse: Physician Attitudes, Beliefs and Practices"

Med Chi Committee on Alcoholism and Chemical Dependency
CME Credits: 1

5:00 p.m. – Scientific Sessions

"Micronutrients and Megavitamins: What's New, What's True"

Med Chi Committee on Mental Health
CME Credits: 1

7:35 p.m. – Baltimore Orioles vs Seattle Mariners – at the new Oriole Park at Camden Yards (Reservations required – space is limited)

SATURDAY, MAY 2, 1992

8:00 a.m. – 12:00 noon – Registration

8:30 a.m. – Mini-Symposium

"Ethics of Dying"

Med Chi Committee on Professional Ethics
CME Credits: 2

8:30 a.m. – Scientific Sessions

"Provocative Radiologic Techniques: Discography, Facet Blocks, and Nerve Blocks"

Maryland Society of Physical Medicine and Rehabilitation and the Maryland Society of Orthopaedic Rehabilitation and Occupational Medical Specialists
CME Credits: 2

"Adjuvant Therapy of Breast Cancer: Prognosis and Perspectives"

Maryland Medical Breast Society
CME Credits: 2

"Therapeutic Gastrointestinal Endoscopy"

Maryland Society of Gastrointestinal Endoscopy
CME Credits: 2

10:30 a.m. – 11:00 a.m. – Break – Visit the Exhibits – Exhibitor Sweepstakes Drawing

11:00 a.m. – Scientific Sessions

"Stereotactic Core Biopsy of Breast Lesions – An Alternative to Surgical Excision"

Diagnostic Breast Center of Cross Keys
CME Credits: 1

"Medical Management in Home Care"

Med Chi Long-Term Care and Geriatrics Committee in cooperation with the American Medical Association
CME Credits: 2

11:00 a.m. – Spouse Program

"Stress in the Medical Marriage"

12:30 p.m. – 1:30 p.m. – Lunch on your own

12:30 p.m. – Small Component Society Caucus

2:00 p.m. – House of Delegates Meeting

3:00 p.m. – Council Meeting

7:00 p.m. – Presidential Banquet

Honoring Med Chi President J. David Nagel, M.D.
(Reservations required – black tie optional)

Note: dates, times, session speakers, and topics in this program are subject to change.

Fun Things To Do



Social Events

Med Chi physicians are invited to participate in a wide variety of social events at this year's meeting. Because space is limited, Med Chi is requiring advance registration for all events. To reserve your space, complete the attached registration form or call Vivian Smith at 410-539-0872 or 1-800-492-1056.

Thursday, April 30

6:00 p.m. – 9:30 p.m. Harbor Cruise aboard the *Lady Baltimore*
Dinner buffet and dancing
(Reservations required – space is limited)

Friday, May 1

7:35 p.m. – Baltimore Orioles and Seattle Mariners at the new Oriole Park at Camden Yards
(Reservations required – space is limited)

Saturday, May 2

7:00 p.m. Presidential Banquet
Honoring Med Chi President J. David Nagel, M.D.
(Reservations required – black tie optional)

For Your Family...Activities In Baltimore

While you attend scientific sessions, your family can visit a wide variety of Baltimore attractions and shops including

Baltimore Zoo	396-7102/366-5466
The Baltimore Museum of Art	396-7100
Edgar Allen Poe House	396-7932
Fort McHenry National Monument and Historic Shrine	962-4299
Harborplace and The Gallery	332-1491
Lexington Market	685-6169
Maryland Science Center	685-5225
National Aquarium in Baltimore	576-3810
Shot Tower	837-5424
U.S. Frigate Constellation	537-1979
Walters Art Gallery	547-9000
World Trade Center – Top of the World	837-4515

A more complete listing of family activities and dining opportunities will be available at the annual meeting.

Hotel Reservations

The Omni Inner Harbor Hotel is the largest hotel in Maryland and offers luxurious guest accommodations.

Med Chi has reserved a limited number of rooms at a special group rate of \$105.00 plus tax for single/double rooms with a \$16 plus tax charge for each additional person. Children under age 15 stay free.

To receive this special discounted room rate, you must make your hotel reservations by **March 29, 1992**.

To make a reservation call: 1-800-THE-OMNI (1-800-843-6664)

Guest check-in time is 3:00 p.m. and check-out time is 12:00 noon.

Telephone Messages

During the meeting, messages may be relayed to registrants by calling 1-410-752-1100.

Directions to the Omni Inner Harbor Hotel

101 West Fayette Street

Baltimore, Maryland 752-1100

- 95 South – Through Fort McHenry Tunnel to 395 North (Exit 53). Follow 395 North 1/2 mile to Pratt Street, turn right. Go two blocks and turn left onto Charles Street. Go four blocks and turn left onto Fayette Street. The Omni is one block ahead on the left.
- 83 South – Take (Exit 23) off 695 to get on I-83 South. Go to end of expressway. Turn right at first traffic light, which is Fayette Street. The Omni is seven blocks on the left.
- 95 North – Take exit 53, which is 395 North. Follow 395 1/2 mile to Pratt Street, turn right. Go two blocks to Charles Street and turn left. Go four blocks to Fayette Street and turn left. The Omni is one block ahead on the left.
- BWI Parkway – North (295)- 295 North becomes Russell Street near Baltimore. From Russell Street, turn right onto Pratt Street. Go five blocks and turn left onto Charles Street. Go four blocks and turn left onto Fayette Street. The Omni is one block ahead on the left.
- 70 East – Follow 70 East to 40 East (Edmondson Avenue). Edmondson Avenue becomes Mulberry Street. Follow Mulberry to St. Paul Street and make a right. Go three blocks to Fayette Street and turn right. The Omni is two blocks ahead on the left.
- 40 West – 40 West becomes (Pulaski Highway) Orleans Street in Baltimore. Turn left at St. Paul Street. Go four blocks to Fayette Street and turn right. The Omni is two blocks ahead on left.



Hotel Information

Parking

The following parking locations are within walking distance of the Omni Inner Harbor Hotel. For your convenience, parking lot locations and prices are listed below.

Valet Parking at the Omni Inner Harbor Hotel

Rates:

\$11.00 per 24-hour period
unlimited in/out privileges

Self Park

Alright Parking

Located at the Omni Inner Harbor Hotel - Because this garage is not owned by the hotel, parking spaces cannot be reserved or guaranteed.

Hourly Rates or:

\$7.00 - 2 - 10 hours
\$9.00 - 10 - 24 hours

Down Under Parking

Rates :

\$8.25 - For any parking over 3 hours
\$3.25 - Flat rate on Saturday & Sunday

Arrow Parking

Hourly Rates or:

\$6.00 - In by 9:30, out by 7:30 p.m.

1st Maryland Garage

Hourly Rates or:

\$9.00 - Maximum for day
\$4.00 - Flat rate on Saturday & Sunday

Park and Lock

Hourly Rates or:

\$9.00 - 3 - 24 hours
\$4.00 - Flat rate on Saturday & Sunday

Fayette West Lot

Hourly Rates or:

\$9.00 - 3 - 24 hours
\$4.00 - Flat rate on Saturday & Sunday



Executive Director's Newsletter

April 1992

Preliminary Program for
1992 Med Chi Annual Meeting

Preliminary Program for 1992 Med Chi Annual Meeting

Preceding this newsletter is the preliminary program for Med Chi's 1992 Annual Meeting, "Mini-invasion and Megatreatments," to be held Thursday, Friday, and Saturday, April 30, May 1 and 2, 1992 at the Omni Inner Harbor Hotel.

Physicians interested in attending this year's meeting are encouraged to complete the registration form on the preliminary program preceding this newsletter. For more information about the meeting contact Vivian Smith at 410-539-0872 or 1-800-492-1056.

Social Events for 1992 Annual Meeting

Med Chi has received a number of calls from physicians wishing to reserve tickets for the Harbor Cruise aboard the Lady Baltimore on Thursday, April 30, 1992 and the Orioles baseball game on Friday, May 1, 1992. Because space is limited for both events, Med Chi has closed advance registration for the Harbor Cruise and the Orioles game. In the event that more tickets become available, Med Chi is maintaining a waiting list for physicians who want to attend either the cruise or the baseball game. Any available tickets will be made available to physicians on the waiting list during the meeting. If you would like to have your name included on the waiting list, contact Vivian Smith in Med Chi's Public Relations Department at 410-539-0872 or 1-800-492-1056.

Form 1099

Many physicians have communicated with the Maryland Medical Assistance Program, Department of Health and Mental Hygiene, relative to changing the 1099 to reflect their group number as opposed to their individual provider number. If the physician billed the Program and accepted payment under his/her individual provider number, the Maryland Medical Assistance Program wishes to inform these physicians that the 1099 cannot be reissued to the group practice number. The Program cannot change 1099s unless an error was made by the Program.

Requests for Claim Reviews Maryland Blue Cross/Blue Shield

Usually, claim reviews require additional information and therefore, the request for review should be done in writing. In order to ensure quick processing of your inquiry

- Use the Information Request Form (IRF).
- Attach a copy of the claim in question.
- Include documentation (medical records, op notes, etc.) that will help to substantiate your request for review.
- Do not send a second inquiry until the carrier has responded to the first inquiry.

There are times when a telephone inquiry is appropriate to request review of a claim. Listed below are the most frequently requested changes and how they must be handled:

Telephone Request Accepted
Date of Injury (if omitted on claim)
Patient's Birthdate (birth year change)
Date of Service (year change only)
Place of Service Code
Patient's Name

Written Documentation Required
Date of Injury (if changing)
Patient Birthdate (entire birthdate)
Date of Service (entire date changing)
Date of Service (Vision Claims)
Frequency of Service
Charges
Diagnosis
Procedure Code
Anesthesia Time

*Provider
Payment/Denial
Appeal Process
Maryland Blue
Cross/Blue Shield*

If you disagree with a claim determination and need to have it reviewed, there are three steps to follow. They are

Step 1. CONTACT THE PROVIDER INQUIRY SERVICE DEPARTMENT

By Phone -

If the payment/denial error is obvious and easy to explain, such as an omitted charge or a charge was listed incorrectly, the claim review may be requested by calling the Provider Assistance and Relations Account Team Number. (See below.)

Account Team Name	Team Code	Name of Acct. Exec.	Local Number	800 Number
INSTITUTIONAL				
Central Maryland	A	Sharon Pettaway	581-3540	800-872-4025
Central Maryland	B	Debbie Wienecke	581-3576	800-544-2279
Eastern Maryland	T	Iris Jones	581-3566	800-628-5647
Western Maryland	T	Iris Jones	581-3566	800-628-5649
PROFESSIONAL				
Eastern Shore	A	Joan Bennett	581-3567	800-628-5648
Western MD	B	Bennett/Marshall	581-3567	800-628-5650
Southern MD	C	Carol Marshall	581-3567	800-626-4113
Surgical/Anes.				
Balto. City	D	Susan Williams	581-3581	800-437-2331
Metro Counties	E	Susan Williams	581-3581	800-437-2332
OB/GYN & Peds	F	Susan Williams	581-3581	800-438-2320
Therapies-PT/Chiropractic	G	Marie Snyder	581-3578	800-437-2321
Laboratory/Radiology	H	Cindie Pollock	581-3575	800-437-2322
Medical/Medical Specialties	I	Kate McCracken	581-3579	800-437-2325
Ancillary Health Care	J	Cliff Franklyn	581-3577	800-437-2328
(DME - Home Health Care - IV Infusion Therapy - Vision Care)				
Mental Health	K	Marie Snyder	581-3578	800-437-2330
Billing Agents	L	Grace Hooper	581-3572	NONE
(Multi Specialty Groups - Sinai Professional)				
Non-Par and Others	M	Marie Snyder	581-3530	NONE
Dental	M	Rosa Nagle	351-3541	800-272-1580
Hopkins, University, (CPPA - Shock Trauma)	N	Grace Hooper	581-3572	NONE

In Writing -

If a corrected claim, operative notes, pathology reports are necessary, please send these items to: Par Correspondence, P.O. Box 811, Owings Mills, MD 21117. Include any information that will help explain the situation. Requests for claim reviews must be received within 60 days from the date of the provider voucher.

Step 2. MEDICAL REVIEW

If a provider wishes to appeal the determination resulting from Step 1, a written request should be made for the claim to be reviewed by the Medical Review department. (Send request to: Par Correspondence, P.O. Box 811, Owings Mills, MD 21117.) Again, pertinent claim information, such as operative notes, pathology reports, photographs for certain plastic surgeries, should accompany the request for the claim review.

Step 3. REFERENCE AND APPEALS COMMITTEE

If a provider wishes to appeal the determination resulting from Step 2, a written request should be made for the claim to be reviewed by the Reference and Appeals Committee. (Send request to: Par Correspondence, P.O. Box 811, Owings Mills, MD 21117.)

*Physician/Population
Ratio Improves*

The physician-to-population ratio increased dramatically between 1980 and 1990, according to the 1992 edition of *Physician Characteristics and Distribution in the United States*. There were 237 physicians for every 100,000 civilians in the U.S. population, a 21.5 percent increase during the last 10 years. Other findings reported in the book:

- The total number of physicians in 1990 was 615,421—an increase of 11.3 percent since 1985 and 31.6 percent since 1980.

- There were 360,995 physicians in office-based practice, a gain of 32.7 percent over the past decade.
- The top three specialties were internal medicine, general practice/family medicine, and pediatrics. The three specialties represented 209,772 (34.1 percent) physicians.
- Some 39.6 percent of U.S. physicians were involved in primary care specialties, a proportion that has held relatively steady since 1980.
- Almost six out of every ten physicians (58.2 percent) in the United States were board-certified, an increase of 50.4 percent over the past 10 years.
- The number of female physicians increased at a rate that was almost four times greater than the rate for male physicians: 91.9 percent versus 23.7 percent respectively from 1980-1990.
- More than half of the physicians in the United States (51.9 percent) were 44 years of age or younger.
- The number of group practices has increased by 54.0 percent from 10,762 in 1980 to 16,579 in 1988.

(*This Week*, February 10, 1992, Volume 2, Number 5.)

Visit Codes

The Health Care Financing Administration (HCFA) has decided to extend the filing deadline for visit codes one additional month. Therefore, carriers are to accept and pay assigned and unassigned claims for the 1991 visit codes at the 1991 payment amounts for claims with January 1 through February 29, 1992 dates of service if the claims are received by April 30, 1992.

HCFA 1500 Billing Form

Medicaid will be ready to accept direct Medicaid billings on the new HCFA 1500 billing form by May 1st. Medicaid will accept crossover HCFA 1500 forms *as soon as they are received from Blue Shield of Maryland*.

Crossover Claims to Medicaid

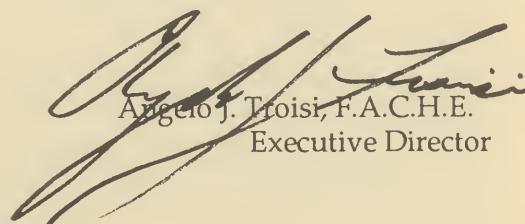
Because of numerous inquiries from physicians, Med Chi requested that the Health Care Financing Administration (HCFA) investigate the problem of claims crossing over from Medicare to Medicaid. As a result of a joint investigation by the State and Blue Shield of Maryland, it was determined that crossover did not occur for the following processing days: October 9, 22, 28-31; November 1, 4-8, 21, 27; or December 12, 20, 1991 or January 6, 8, 17, 1992. Please alert your billing staff about these dates.

Med Chi Semiannual Meeting

Mark your calendars! Med Chi's Semiannual Meeting will be held Friday, Saturday, and Sunday, September 18, 19, and 20, 1992 at the Princess Royale Hotel in Ocean City, Maryland. For more information about the Semiannual meeting, watch the Executive Director's Newsletter.

New CPT Evaluation and Management Codes for 1992

In a continuing effort to keep you apprised of the latest developments in CPT evaluation and management codes for 1992, Med Chi will be providing a listing of commonly asked questions and answers following this newsletter. This list was prepared by the Health Care Financing Administration. Watch the EDN for additional questions and answers about CPT codes in the coming months.



Angelo J. Troisi, F.A.C.H.E.
Executive Director

New CPT Evaluation and Management Codes for 1992

Questions and Answers

(These questions are part of an ongoing listing of commonly asked questions about CPT Codes.
To review the first ten questions, see the March 1992 Executive Director's Newsletter)

11. If a patient is admitted as an inpatient and discharged on the same day, may the hospital discharge day management code be reported?

No. To report services to a patient who is admitted as an inpatient and discharged on the same day, use only the appropriate code for initial hospital inpatient services—Codes 99221-99223.

12. May a physician report an emergency department visit or an office visit and a comprehensive nursing facility assessment on the same day?

No. Evaluation and management services on the same date provided in sites other than the nursing facility are "rolled-up" into the initial nursing facility care code when performed on the same date as the nursing facility admission. For a complete explanation, see page 33 of the 1992 CPT book.

13. Similar to the above, may a physician report a nursing facility visit and an initial hospital visit on the same day?

No. Both of these visits are "rolled-up" into the initial hospital visit. Hospital visit descriptors include the phrase "per day" meaning they include all care for the day. For a complete explanation, see page 18 of the 1992 CPT book.

14. May a critical care code and other procedure codes be reported on the same day? Will Medicare pay for both services?

The critical care codes are intended to include all critical care services performed during the critical period that require the constant attention of the physician (e.g., cardiac arrest, shock, bleeding, respiratory failure, postoperative complications, critically ill neonate). Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit, or the emergency care facility. Other procedures that are not directly attendant to critical care management (e.g., setting of fractures, bladder tap) are not included in the critical care code and should be reported separately. See page 31 of the 1992 CPT book for further information.

Medicare will pay for all services that are medically necessary.

15. If a physician provides critical care for 1 hour and 15 minutes, how should the services be reported? Should code 99292 (for an additional 30 minutes) be reported? Should the reduced services modifier be used?

For the first hour of critical care, code 99291 should be reported and no modifier should be used. For the additional 15 minutes, code 99292 should be reported using modifier "-52" for reduced services.

16. Will Medicare pay for both a critical care service and an emergency department service on the same date for the same patient?

The answer depends on the circumstances. If critical care is required (codes 99291 and 99292) upon presentation to the emergency department, no other evaluation and management codes will be paid for by Medicare.

The answer would be different in the following example. A patient presented in the emergency department with mild chest pain. After evaluating the patient, a decision was made to release him. However, just prior to his departure he suffered a cardiac arrest. Medicare would pay for both the emergency department services and the subsequent critical care services.

17. Will Medicare pay for both a hospital visit and critical care on the same day for the same patient?

Possibly. For example, if there is a visit early in the day and at that time the patient does not require critical care, but the patient requires critical care later in the day, Medicare will pay for both services.

18. May a physician report two hospital visits on the same day to the same patient for unrelated problems?

No. The inpatient hospital visit descriptors contain the phrase "per day" meaning all services provided on that day. The code selected should reflect all services provided for the day.

19. May a physician report two office visits on the same day to the same patient for unrelated problems?

Yes. In the office or outpatient setting, two office visits may be reported.

20. Following a consultation, the consulting physician assumes responsibility for the patient's care. How should the services be reported? What will Medicare pay for?

The initial consultation should be reported using the appropriate consultation code. Medicare payment would be made for that code. If the consulting physician then assumes responsibility for the patient's care, subsequent visits should be reported as established patient office visits or subsequent hospital care, depending on the setting.

Progress in physician rehabilitation

Edson B. Moody, M.D.

Dr. Moody is an internist in Washington County and a member of Med Chi's Physician Rehabilitation Committee.

This issue of the *Maryland Medical Journal* has been made available to the Physician Rehabilitation Committee of the Medical and Chirurgical Faculty of Maryland in order to present several important aspects in the recovery of the impaired physician. The emphasis is not just on intervention and rehabilitation, but on how successful long-term physician recovery can be.

The paper by Patrick Hughes et al takes an insightful view into the problem of substance abuse by medical students and residents. The papers from Edward Reading in New Jersey, Donald Meek in Washington, DC, Karl Gallegos et al in Georgia, and Fred Alpern et al in Maryland, all deal with long-term physician recovery and outcomes. Robert White et al present guidelines for physician assistance committees in individual hospitals.

Those of us involved in physician rehabilitation have been concerned about how successful we are at what we do. Are we making a difference? How well are we doing? And, what is it that makes a program successful? The answers from these articles is a resounding yes—we can help turn around lives (both personal and professional) and with ongoing care and follow-up, we are doing it well. These reports give success rates ranging from 75 percent to 97 percent, which are excellent given the high failure rates seen before the establishment of physician rehabilitation committees. All of the programs reviewed here stress the absolute necessity of continued involvement by the rehabilitated physician in recovery programs such as Alcoholics Anonymous and Narcotics Anonymous. Detoxification and an inpatient or outpatient care program of intensive rehabilitation therapy are only the beginning. Alcohol and other substance abuse are chronic diseases, and must be addressed as such by the treating physicians as well as the physician recovering from impairment. There is no place for Band-Aid therapy. These papers are excellent testimony to this concept.

It has been my privilege and pleasure to assist in gathering the various articles presented here. After my initial conversation with the various authors, I had the feeling that the data were out there waiting to be gathered, analyzed, and put down in writing. I am pleased to have had a part, not only in the selection of the authors and the topics, but also in encouraging the authors and researchers to complete their tasks. ■

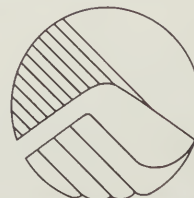
COMING OUT OF THE DARK

Med Chi's Physician Rehabilitation Committee deals with the substance abuse and mental health problems of Maryland physicians, with a confidential and nondisciplinary focus...Addiction, Marital/Family Conflicts, Psychiatric Illness, Organic Impairment, Physical Handicap...If these problems exist, we can help find the solution. Call us.

The Physician Rehabilitation Committee of Med Chi is available to all Maryland physicians, and their families. The Committee is NONDISCIPLINARY and information is kept CONFIDENTIAL. If you, a colleague, or family member is in need of our services call (301)962-5580 or call toll free (800)992-7010, or leave a message 24 hours a day, 7 days a week at (301)727-1020.

HELPING IS OUR BUSINESS...All donations to the Physician Rehabilitation Committee are used for the delivery of services to Maryland physicians in need of help. If you wish to help further the work of the Committee through a tax deductible donation send your check to: The Medical and Chirurgical Faculty Charitable/Educational Foundation, 1204 Maryland Avenue, Baltimore, Maryland 21201 Please note on your donation: "Physician Rehab"

Medical
and Chirurgical Faculty
of Maryland



**Physician
Rehabilitation
Committee**

The Physician Rehabilitation Committee of Maryland: The early years

Joseph F. Chambers, M.D.

Dr. Chambers is a psychiatrist in Montgomery County specializing in addictionology and was one of the members of Med Chi's first physician rehabilitation committee.

The Physician Rehabilitation Committee was formed at the 1977 summer meeting in Bermuda of the Medical and Chirurgical Faculty of Maryland (Med Chi). The planners included Drs. Joseph Berman, Maxwell Weisman, Charles Bagley, and James Davis. The first chairperson was Jerome J. Collier, M.D., an internist from Pikesville. He was a former chairperson of the Commission on Medical Discipline and could no longer accept sick physicians losing their medical licenses in Maryland. The committee was established at the direction of the executive council of Med Chi. The committee first met on October 10, 1977, under Dr. James Davis, the 1977–1978 president of Med Chi.

In the first year (The Class of '78), the committee dealt with thirty-five physicians with an average age of 53 years. These were primarily older general practitioners who often had physical problems. Many required detoxification and rehabilitation. Several died of their active disease, some retired, and a few left the state of Maryland. Still, most did recover.

Under Dr. Collier's energetic direction, physician therapy groups began in Baltimore, in Bethesda, and on the Eastern Shore. Enthusiastic physicians formed teams of two or three in the early years. The teams traveled from Oakland in Garrett County to Chrisfield in Somerset County to see their troubled colleagues. These doctors were Robert McDermott, William Dixon, Leo Hennigan, Timothy Barilla, John Griswold, Robert Kent, Patrick Adams, Edson Moody, Edward Kitlowski, Michael Bisco, Michael Hayes, Richard Anderson, Irving Cohen, Robert McDaniel, and Martin Valaske. They all devoted many hours, some, hundreds of hours, to their fellow physicians' recovery. Sister Mary Thomas was a constant support to all the members of the committee.

In a few years, the treatment contracts were organized and procedures and guidelines were established. All the while, Constance Townsend, assistant to Med Chi's executive director, provided continued support for the committee and kept things together. The executive council supported the committee, the county medical societies invited the committee in, and the auxiliary had a representative. From 1977 to 1985, the Physician Rehabilitation Committee made a difference in the lives of over 200 physicians.

Personally, those early years with the committee were the most productive and rewarding of my professional life. They were often difficult and frustrating, but always worthwhile. I am grateful for the honor and the privilege to have had a piece of the action in the recovery of my fellow physicians. ■

Sign for the times.



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"At the Med Chi meeting, come visit our booth #105 for a free key."

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubiaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

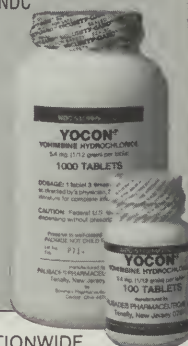
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

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A survey of recovering Maryland physicians

Frederick Alpern, M.D.; Catherine E. Correnti, NCAC II;
Thomas E. Dolan, NCAC II; Michael C. Llufrio, NCAC II;
and Anne Sill, B.S.

In a survey of physicians who had participated in the Maryland Physician Rehabilitation Program, 75 percent of the respondents reported that they were in recovery, with a mean recovery duration of eighty-eight months.

Dr. Alpern is a psychiatrist in private practice and a member of Med Chi's Physician Rehabilitation Committee; Ms. Correnti is a nationally certified addiction counselor and the physician rehabilitation advocate for Med Chi's Physician Rehabilitation Program; Mr. Dolan is a nationally certified addiction counselor and the outreach coordinator for Med Chi's Physician Rehabilitation Program; Mr. Llufrio is a nationally certified addiction counselor and the director of Med Chi's Physician Rehabilitation Program; and Ms. Sill is a data manager and analyst for the University of Maryland Division of Human Genetics, and a consultant for Med Chi's Physician Rehabilitation Program.

Since the publication of "Prognosis of physicians treated for alcoholism and drug dependence,"¹ a greater than 83 percent success rate for chemical dependency recovery has been reported for physicians. This figure has been regarded with a great deal of skepticism in the treatment community. The skepticism is understandable when the physician recovery rate is compared with the general population's much lower success rate of 47 percent.¹

To contrast results in Maryland with recovery data cited in the literature for physicians and the general population, the Maryland Physician Rehabilitation Program (PRP) conducted a survey to examine the quality of recovery for physicians who graduated from the PRP. (The PRP is guided by the Physician Rehabilitation Committee of the Medical and Chirurgical Faculty of Maryland, which was established in 1978. Its purpose is to receive referrals of allegedly impaired or, in many cases, "wounded" physicians. Referrals come from a plethora of sources including self-reports and reports from families, colleagues, hospitals, office staff, friends, and the Maryland Board of Physician Quality Assurance.) Ninety-two physicians responded to a one-time mailed survey, with seventy-eight of the respondents providing sufficient information for data analysis.

In addition to overall recovery rates, the quality of recovery was measured by rating physician participants' perceptions about the quality of their life prior to and subsequent to PRP involvement, as well as their current functional capacities.

Demographics

Distribution of age, sex, and race for respondents was as follows.

Mean age	54 (Age range: 32–78 years)
Male	80 percent
Female	20 percent
White	74 percent
Asian	11 percent
African-American	8 percent
Hispanic	4 percent
Oriental	3 percent

Medical practice

Eighty-eight percent of survey respondents reported that they were still practicing physicians. Of the 12 percent who reported that they were no longer practicing, 80 percent had retired. Of those who reported retirement, the mean age was 67.2 years. Twenty percent of those no longer practicing indicated that they were not practicing for other unidentified reasons.

Respondents' primary and secondary medical specialties are reported in Table 1. Respondents' impairments included alcoholism, 67 percent; narcotics abuse (Hycodan, percodan, Demerol, codeine, fentanyl, morphine, opiates, oxycodone, meperidine, stadol, and paragorics), 21 percent; stimulants abuse (Dexedrine, cocaine, and amphetamines), 16 percent; sedatives/hypnotics abuse (barbiturates, benzodiazepines, diazepam, Valium, Xanax, Fiorinol, Surital, and Placidyl), 23 percent; other drug abuse (marijuana), 3 percent; psychiatric illness, 12 percent; physical illness, 4 percent; and other illness, 9 percent. These data reflect distributions that have remained constant during the program's existence, with alcoholism and chemical dependency being the most common impairment.

Respondents were asked to report the initial treatment modality to which they were referred by the PRP. The modalities used and the frequency of use of each mode of treatment are presented in Figure 1.

Survey results further revealed that 62 percent of respondents were currently in some form of supportive therapy and/or were using self-help fellowships. Thirteen percent reported group therapy involvement, 19 percent individual therapy, and 47 percent were active in self-help fellowships (44 percent Alcoholics Anonymous, Narcotics Anonymous,

or Chemical Dependents Anonymous; 3 percent Alanon or Naranon; and 1 percent Adult Children of Alcoholics or Codependence Anonymous).

Recovery

Of the physicians who responded to the survey, 75 percent reported they were in recovery from their illness, with a mean recovery duration of eighty-eight months.

When asked to rate the current status of their family relationships and their occupational functioning, the majority of respondents assessed themselves as highly functional in these two primary life areas (Table 2).

One of the chief goals of the PRP is to intervene with a physician early in the course of his or her illness, before a pathological process progresses to where the ability to practice medicine is compromised and, therefore, adversely af-

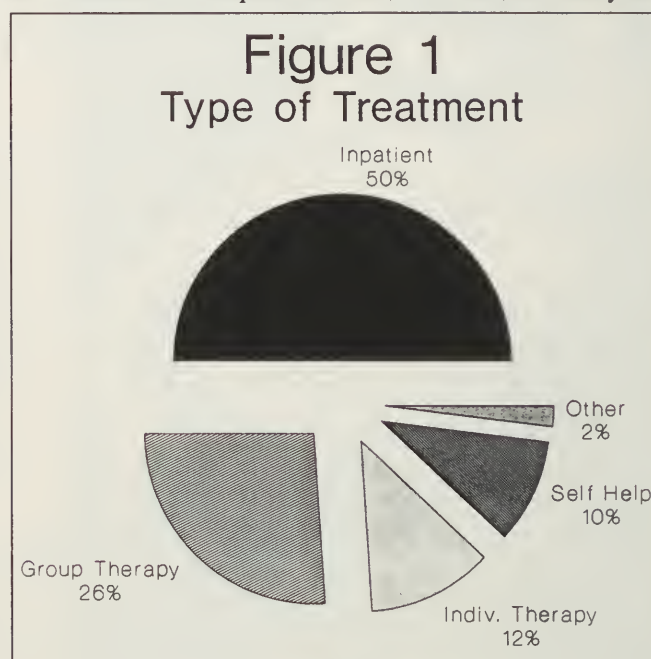


Figure 1.

Table 2. Functional Status

Family functioning	Respondents (%)
Nonfunctional/Alone/Isolated	0
Severe family dysfunction/ Difficulty making friends	3
Some family dysfunction/Healing	0
Family improving/Established some new friends	10
Family functioning well/Forming new appropriate relationships	87
Occupational functioning	Respondents (%)
Not functioning/Not seeking employment	1
Not functioning/Seeking employment	3
Minimal functioning/2-day work week	3
Moderate functioning/Working part-time or over time	4
High functioning/Working 3/4 time with minimal overtime	7
Optimal functioning/Working full and appropriate time	82

Table 1. Respondents' Medical Specialties

Medical specialties	Primary	Secondary
Family or general practice	27 %	
Psychiatry	11 %	
Surgery (otolaryngology, ophthalmology, obstetrics/gynecology)	13 %	1 %
Internal medicine (cardiovascular disease, nephrology)	26 %	1 %
Anesthesiology	5 %	3 %
Pediatrics	9 %	
Other (emergency medicine, addictionology)	7 %	13 %

Note: Due to rounding, totals do not equal 100.

fectured. Twenty-one percent of respondents reported negative consequences as a result of their impairment (Table 3).

Table 3. Consequences as result of impairment

Consequence	Percent
Suspension of drivers license	19
Loss of practice partnership	25
Loss of hospital privileges	13
Suspension of medical license	19
Revocation of medical license	6
Other	13

Note: Due to rounding, total does not equal 100.

Respondents were asked to rate (1= very poor, 5 = very good) the quality of their lives prior to entrance into the Physician Rehabilitation Program and at the time of the survey (Table 4). Respondents' reports

showed a significant improvement in their assessment of the quality of their life after their involvement with the Physician Rehabilitation Program (Figure 2). Additionally, 75 percent of respondents reported their experience with the PRP as being "Fair" to "Very Good." A few rated their experience with the PRP more negatively as a result of treatment experiences encountered outside of the program. Overall, respondents were very forthright with their comments and criticisms, most indicating their gratitude for the PRP's assistance.

Upon initial examination, the 75 percent overall recovery rate reported by respondents in this survey appears lower than those cited by other studies. However, the 83 percent recovery rate cited in the Morse study was based only on data related to alcoholism and drug abuse recovery, whereas this survey's overall rate of recovery was determined by incorporating physicians with all types of impairments. In the PRP survey, the rate of recovery was 86 percent for those with alcoholism and 90 percent for those with drug addiction. Our high overall rates of recovery as compared with recovery rates in the general population may be due, in part, to the PRP's close monitoring and support of program participants, as well as the fact that physicians may have a great deal more to lose than members of the general population. It has been suggested that the motivation to recover is stronger when the occupation at risk is high status, competitively sought, and identified closely with personal image and prestige.¹

Recently, the Maryland PRP has begun to use a five-year contract of monitoring and advocacy. This increased duration of monitoring is being used nationally, as it is anticipated that a longer period of monitoring will provide a better foundation for long-term (lifetime) recovery.

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Table 4. Quality of life assessment

Prior to PRP entry		At time of survey	
Very poor	30 %	Very Poor	0 %
Poor-Fair	20 %	Poor-Fair	0 %
Fair	27 %	Fair	3 %
Fair-Very Good	11 %	Fair-Very Good	22 %
Very Good	12 %	Very Good	75 %

Figure 2
Quality of Life

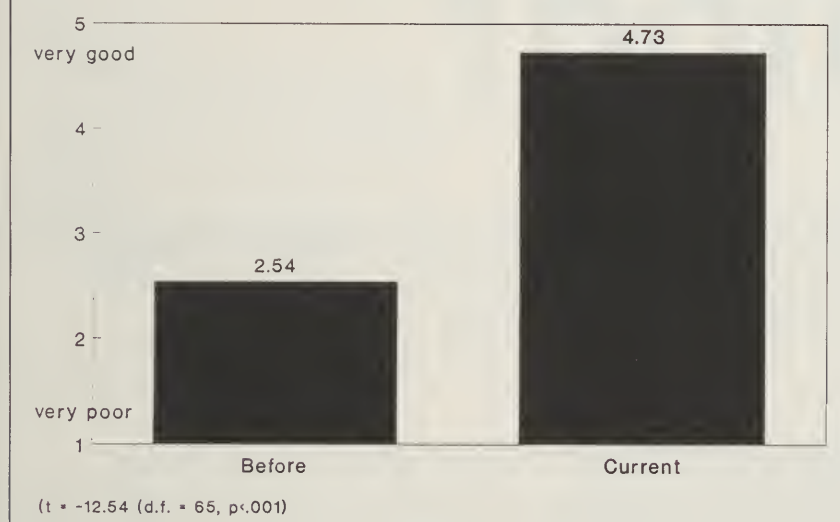
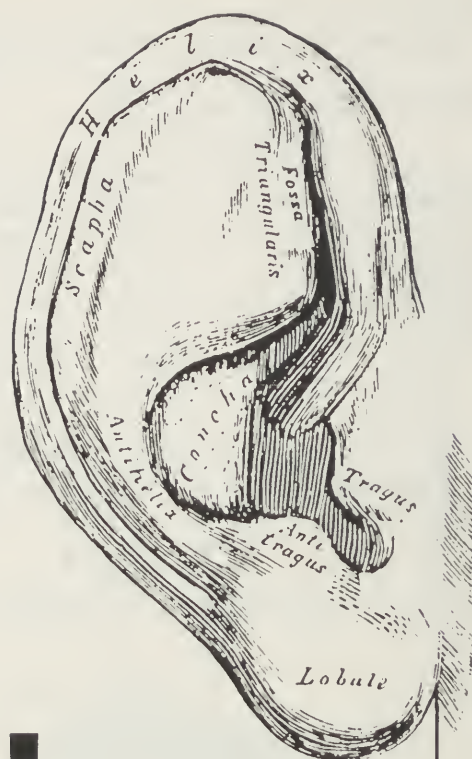


Figure 2.

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Hospital-based professional assistance committees: Literature review and guidelines

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This paper presents a review of the current literature on hospital professional assistance committees, a discussion of key issues, and a set of guidelines for the design and operation of these committees. The employee assistance program is suggested as a resource to these committees.

Much progress has been made in the field of physician impairment since the landmark article, "The Sick Physician," was published by the AMA Council on Mental Health in 1973.¹ The idea that a physician's ability to practice can suffer from such diseases as addiction, depression, or other psychiatric disorders is now widely accepted. State medical societies have made considerable progress in developing effective programs to identify and treat impaired physicians.^{2,3} Many state licensing boards have begun to work collaboratively with impaired physician committees in order to assure that sick physicians get the treatment they need to recover. The network of helping groups that has developed over the last twenty years is impressive.

In most states, however, hospitals have not been directly integrated into this process. (California is a notable exception.) Hospitals have relied on normal peer review activities to deal with the problem of an impaired physician.^{4,5} However, greater demands for corporate responsibility (i.e., liability) are being felt. Hospitals are being held accountable for the actions of their practitioners.^{6,7} Specifically, they are being asked to provide reasonable and adequate measures to identify and monitor physicians who may have had alcohol, drug, or psychiatric problems.⁸⁻¹¹

Hospitals represent a vital yet underdeveloped part of the helping network. The immediate colleagues and coworkers of a physician may be the first to notice that there is a problem needing attention. These coworkers will be more likely to call on an in-house group for assistance than an outside group. This makes it essential that there is an avenue within each hospital that can serve as a point of contact regarding impaired physicians. A hospital professional assistance committee (PAC) can serve as a valuable resource in this regard. This article will review the literature on these committees, describe the PAC at the University of Maryland Medical System, and discuss guidelines to set up similar committees.

Review of the literature

The literature on hospital impaired physician committees is about fifteen years old, with most articles appearing within the last ten years (1981–1991). A few of the publications offer suggestions about the design and function of hospital committees^{12–15} although the publications present widely different opinions on key issues. Most of the literature deals with the subject in a general way or is focused on a specific perspective such as legal liability.

The following discussion reviews the literature available on committee membership, confidentiality, recordkeeping, intervention procedures, coercion, committee activities, and legal issues.

Membership. There are widely divergent opinions about who should serve on a hospital committee. One school of thought clearly favors including physicians and others with authority, such as the president of the medical staff and the chief executive officer (CEO).^{5,14} Others stress that membership should be restricted to well-respected members of the medical staff who have no position of authority within the hospital.^{15–19} The concern of this latter group is that colleagues would be more likely to refer a physician to a nondisciplinary, confidential committee; the presence of authority figures would dampen that image. There is general agreement that no member of a peer review committee should also serve on the PAC.^{15–19} Any appearance of a conflict of interest should be avoided.

Confidentiality. There is significant disagreement about confidentiality regarding a hospital committee. On one side is the group that wishes the committee to be fully incorporated into the hospital administrative process so that the names of all reported physicians would be known to the hospital leadership.^{5,14} The other side wishes to operate in complete secrecy; no names would be recorded and no committee activities would ever be known, except to the committee itself.^{15,18,19} The arguments for and against stem from the authors' perspectives on patient care versus concern for the individual physician.

Intervention. Many committees have adopted the Talbott approach to intervention²⁰ whereby several committee members are assigned a case and then quietly approach the individual on one or more occasions in order to insist that s(he) seek appropriate treatment. If the committee members are unsuccessful, they may or may not report the case to the hospital administration. Crosby, Bissell, and others^{21–23} have outlined effective intervention methods for professionals that generally use consequences for noncompliance (e.g., a report to the appropriate authority).

Coercion. Many articles argue strongly for noncoercive measures, even if an identified physician has failed to comply with treatment recommendations.^{15,18,24} These authors take an advocacy-only perspective for the impaired physician and do not believe that it is appropriate for a PAC to cooperate with the physician discipline system in any way. Other articles encourage immediate notification of the disciplinary

bodies in order to safeguard patient care and reduce hospital liability.^{5,14}

Committee activities. The literature also varies widely on the nature of activities that are appropriate for a hospital PAC. Some authors recommend that the committee take an information and referral role only.^{15,19,25} Others believe it is essential for the committee to adopt a hands-on approach and to become actively involved in the identification, evaluation, monitoring, and advocacy of the impaired physician.^{5,14,16,24} Still others encourage the hospital PAC to act only with the approval of the state medical society program.²⁵ Most authors suggest that the PAC serve an educational role in the hospital community by organizing events promoting awareness of the committee and the issue of impairment among physicians.

Legal issues. The primary legal concern that has arisen over the years is the issue of corporate liability. Hospitals are being held responsible for the actions of their medical staffs.^{6,7,10} Hospitals can no longer leave the behavior of an impaired physician for the review of the medical society. Hospitals are now required to set up reasonable monitoring systems that will protect the patients from any harm that may befall them due to the inappropriate actions of an impaired practitioner.^{8,9,11} Hospitals must attempt to identify physicians who have had problems in the past and make sure that they are in stable recovery. The new emphasis on drug testing will only increase the pressure on hospitals to have these procedures in place and to act with sensitivity to the issues of patient care and due process for the physician.

Another legal concern discussed in the literature on hospital PACs is immunity. In some states (such as Maryland), the committee members are legally immune to any civil suit (as long as they have acted in good faith).²⁶ This is an important factor in allowing the committee and the impaired physician's colleagues to act without fear of civil suit by the identified physician. In Maryland, the immunity law applies to all medical review committees and all individual physicians who make reports to and/or work with such committees.

The University of Maryland Medical System's Professional Assistance Committee

The University of Maryland Medical System (UMMS) PAC was established as a standing committee of the medical staff in 1988. (There are about 1,500 physicians on the medical staff—900 attending and 600 residents.) The PAC originally offered information to the hospital community about impaired physicians and served as a referral source for the state medical society's program. The employee assistance program (EAP) staff were added to the committee in 1989, and the committee began to take a more active role in dealing with impaired physicians. The number of cases increased from three during the first year to nineteen as of September 1, 1991. The majority of the cases have been related to alcohol and/or drug dependence. The remaining cases (about 20 percent) were related to psychiatric or interpersonal problems. Referrals to the committee have come from a variety of sources including the board of medicine, the state medical

society, the credentials committee, department chiefs, and the EAP.

Medical staff affiliation. It has been important for the committee to be established as a formal part of the medical staff organization. This affiliation has insured that the committee operates according to procedures that have been approved by the medical staff, and that the committee is accountable to the hospital. When committees are set up on an informal basis, they become concerned solely with the well-being of the individual physician and sacrifice the important role of protecting patient care. The real mission of these committees is to balance these two goals carefully, recognizing the overriding concern of patient care while dealing compassionately with the needs of a sick physician.^{1,27}

An informal committee is less likely to use the potent leverage of referral to the appropriate authority as a way to influence an addicted physician to seek treatment. An informal committee is also less effective as an advocate for the recovered physician because the members are not recognized as legitimate spokespersons by an outside authority such as a state board of medicine, a malpractice carrier, or a credentials committee.

State medical society. The UMMS PAC has formed a strong working relationship with the state medical society program (Med Chi's Committee on Physician Rehabilitation). The two committees work together on many cases and have arranged for on-site follow-up and urine monitoring through the EAP office. The medical society uses the PAC as a local resource in the hospital. The PAC, on the other hand, calls on the medical society program for assistance in evaluation, intervention, and advocacy for many cases. Since the activities of both committees are confidential, they can offer the identified physician a safe avenue for treatment and recovery, as long as the physician is compliant with the treatment agreement.

In some cases, the PAC has found that it is more effective to have the medical society program intervene from the start. This is true when a physician is especially resistant to treatment and is not cooperative in any way. The medical society's involvement adds an additional sense of importance to the case and it lets the physician know that failure to comply will result in a report to the state board of medicine (Board of Physician Quality Assurance).

Employee assistance program. It is ironic that many hospitals already provide an assistance program for all of their staff *except* physicians, since physicians are not generally salaried employees. The EAP is a well-established model for providing free, confidential counseling to employees and their families.²⁸ The UMMS EAP can assess personal problems such as alcohol and drug dependence, depression, and family problems, and develop an appropriate treatment plan. Whenever possible, the EAP provides short-term counseling to resolve the problem. Otherwise, the employee is matched with a specific treatment provider.

Supervisors often refer employees to the EAP for evaluations because of job performance problems. Attendance

problems or deteriorating job performance can be symptoms of an underlying addiction or psychiatric problem. The EAP evaluates, refers to treatment, and monitors ongoing progress for supervisory referrals.

The hospital committee functions in the same fashion as the EAP but deals only with physicians. The committee accepts referrals from a variety of sources, arranges for specific evaluations, refers physicians to treatment, and monitors physician compliance to the treatment plan. In addition, the committee advocates for the physician as long as s(he) is in compliance with the treatment agreement.

Two of the major obstacles for professional assistance committees are a lack of paid staff to coordinate the work of the committee and a lack of specific expertise in addiction treatment. Linking the hospital PAC with the EAP helped to resolve both of these needs at UMMS. The committee functions as a specialized EAP for physicians—coordinating evaluations, referring physicians to treatment, monitoring progress in treatment, and serving as an advocate for persons in recovery. The committee members, though all physicians, may not be experienced in managing the treatment of an alcoholic, drug dependent, or psychiatrically impaired person. The EAP staff are trained in addiction treatment and can provide a level of expertise that may not be available otherwise.

The EAP has also provided the essential service of collecting observed urine screens. Urine drug screens are very important in evaluation and ongoing monitoring of addicted physicians. The universal problem is finding a suitable and reliable way to collect the specimen.

Committee membership. The UMMS PAC has excluded physicians and others in positions of authority such as the CEO, the president of the medical staff, and department heads. In order for the committee to operate, it must rely on the hospital community for referrals. Colleagues, coworkers, and staff are less likely to report a physician to a committee whose activities are not confidential or that appears to be disciplinary in nature. Also excluded from committee membership are persons who are currently members of a peer review committee or a credentials committee for the hospital. The committee has encouraged the participation of physicians who have been in recovery from addiction for at least two years.

Physician orientation. The UMMS PAC has been set up as a standing committee of the medical staff and is designed to deal with physicians. However, in some cases a nonphysician (e.g., nurse, dentist) has been referred to the committee and the committee has managed the case. This has occurred when the professional has clinical credentials through the medical staff. It has been important to develop a sense of peer support by making it clear that the committee is for physicians. Colleagues are more likely to refer to a committee of their peers.

The same is true for nurses. The UMMS Nursing Department has developed a separate impaired nurse committee that works with the EAP to provide information and referral services to the hospital community. Since all nurses are covered by the EAP as employees of the hospital, it is easier to arrange for evaluation and treatment.

Reporting noncompliant cases. The PAC has found it to be essential that any noncompliant cases (or any case that represents a danger to patient care) be reported to the appropriate authority (medical staff president, department head, board of medicine, or medical society). The only way for a committee to effectively motivate an addicted or impaired physician to seek treatment is to offer an informal, confidential, nondisciplinary process as an alternative to a formal, public, disciplinary procedure. This leverage is essential to ensure that the impaired physician will accept help. Committees that fail to use this leverage do not understand addiction treatment and abdicate their responsibility to patient care.

It could also be argued that failure to report an addicted or impaired physician who has refused to comply with treatment is tantamount to "enabling." Enabling is the term used to describe the actions of well-meaning persons who protect addicts or alcoholics from the consequences of their behavior and, thus, allow (enable) the disease to progress unchecked.

Recordkeeping. The UMMS PAC keeps regular minutes at the committee meetings but does not record names or other identifying information. The status of cases is reviewed during the meetings but only code numbers are used in the minutes. All client records are kept in the EAP files as confidential files. These records are protected by the federal confidentiality regulations that apply to all EAPs and alcohol/drug abuse programs. Documentation kept in the client record includes evaluations, urine screen results, treatment contracts, correspondence, progress notes, and any written material related to the case.

An ongoing case record is essential in the management of an impaired physician. Cases may be monitored for five years or longer, and detailed knowledge of the individual's progress is necessary to make sound decisions about treatment planning. It is also very important to the individual physician who has achieved recovery to be able to document that recovery through letters of support from the committee. This would be impossible without a formal case record.

Committee activities. The PAC engages in the following activities: receiving reports, discreetly collecting information, interviewing identified physicians, referring physicians to specialists for evaluations, referring physicians to the medical society, referring physicians to treatment, establishing treatment contracts (agreements), monitoring compliance with treatment contracts, coordinating urine screens, reporting noncompliant cases to appropriate authorities, providing support and advocacy to recovered physicians, and educating the hospital community about impairment.

The PAC does not offer treatment services nor does it provide formal evaluations. The committee members only perform committee work. They do not practice medicine or provide addiction treatment with individuals who are referred to the committee. When a documented evaluation is required, then the physician is referred to an outside professional who specializes in the area relevant to the physician's difficulty (e.g., psychiatry, addiction, neurology). The committee acts on the written recommendations of an outside specialist. This

distinction becomes quite important when a physician is resistant to treatment and a report must be made. It is essential for the committee to be acting on documented recommendations from a professional who is experienced in that area. Committee members have to be careful to wear one hat at a time.

Summary and guidelines

Hospitals are a very important part of the helping network that can assist the impaired physician. Hospital medical staff are in a position to notice a problem before it comes to the attention of a state organization. A hospital PAC is an effective way to extend the helping network and enhance the work that is being done by the state medical societies. These hospital-based committees can work collaboratively with the state level programs to identify and monitor impaired physicians. The following guidelines are based on a review of the literature and the experience of the University of Maryland PAC.

1. Begin by establishing a professional assistance committee, through the medical staff, that will provide educational activities and serve as a resource to the hospital.
2. During the first year of operation
 - a. Meet with representatives of the state medical society's impaired physician program (where available), and determine ways that the two groups can work together;
 - b. Assess the level of addiction expertise that is available to the committee;
 - c. Explore the possibility of paid support staff such as a certified employee assistance professional (CEAP) or a certified addictions counselor (CAC);
 - d. Meet with hospital legal counsel to discuss operation of the committee including immunity, recordkeeping, and reporting requirements; and
 - e. Meet with representatives of the state licensing board to establish a cooperative relationship.
3. The bylaws should be designed to
 - a. Exclude from membership persons in supervisory positions and physicians who serve on a peer review or credentials committee;
 - b. Clearly establish that the committee can function confidentially unless the identified physician is noncompliant with treatment or presents a danger to patient care (noncompliant physicians will be referred to the appropriate authority);
 - c. Include members and paid staff (e.g., EAP) who are experienced in addiction treatment;
 - d. Encourage a strong working relationship with the state's impaired physician program, where one exists; and
 - e. Clearly describe the activities of the committee.
4. Decide on the advisability of including other professional groups (e.g., nurses, pharmacists) based on the size of the hospital and the needs of the professional community.
5. Promote awareness of the committee through printed materials and educational events.

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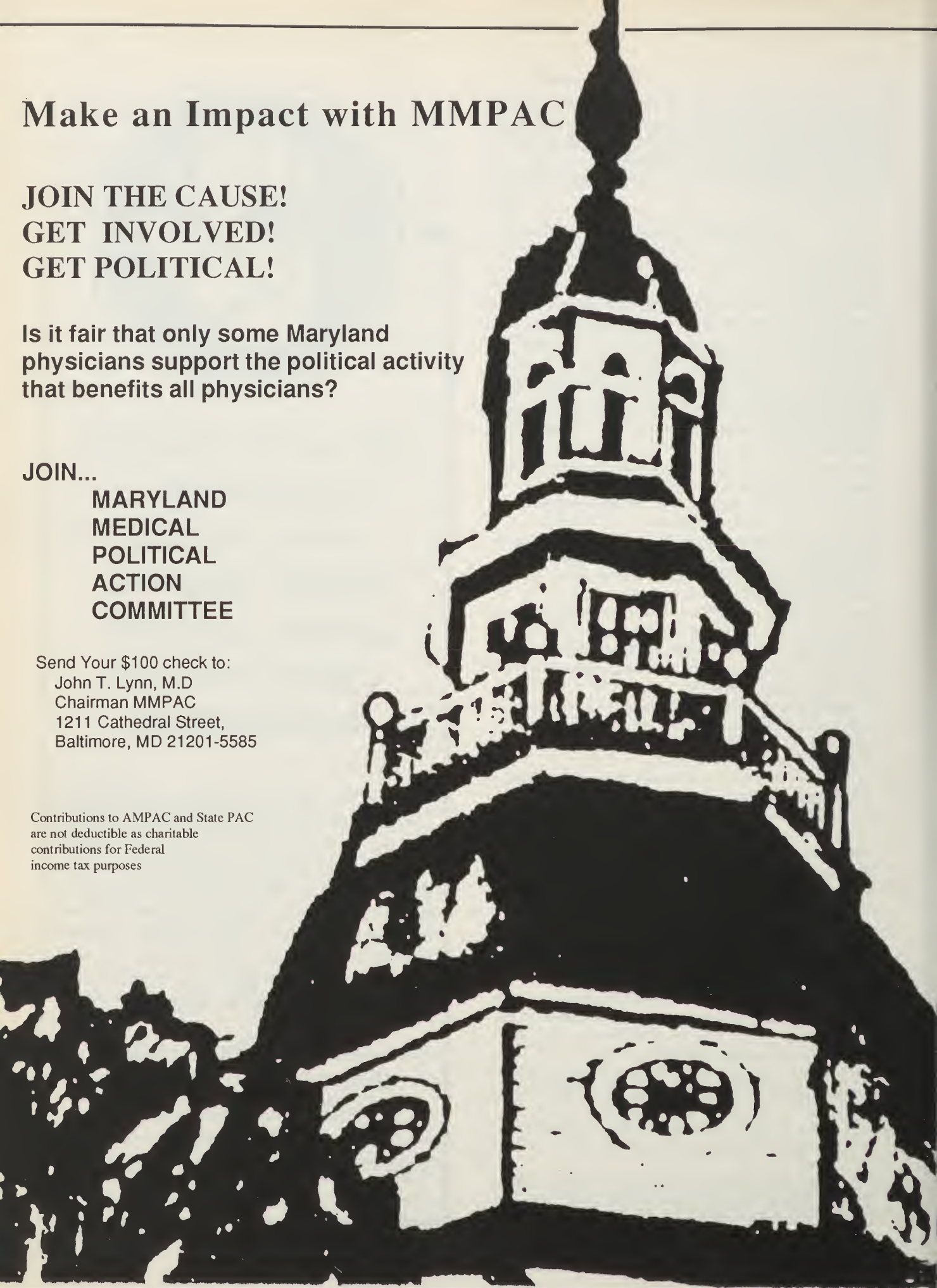
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Patterns of substance use in the medical profession

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National drug use surveys of medical students and resident physicians in 1987 found that medical school was not a time when students began to use drugs, nor was it a time when they engaged in heavy use. Medical students and resident physicians reported lower rates of illicit drug use than their age and gender counterparts. Although males generally were more likely to use substances than females, young male and female physicians resembled one another in their current rates of substance use more than they resembled their gender counterparts in society.

As reports of cocaine use and dependence became more widespread in the mid 1980s, there was concern over the lack of current data on medical student use of cocaine and other drugs. This provided a stimulus for a series of national studies on substance use in the medical profession and led to the establishment of a Center for the Study of Impaired Professionals in the University of South Florida, Department of Psychiatry.¹

The studies focused on medical students, residents, and practicing physicians and were patterned after survey research underway on substance use among US high school graduates,^{2,3} college graduates,^{2,3} and households⁴ to allow comparison with substance use trends in the general population. Questions for the medical student and resident surveys covered demographic characteristics, substance use, reasons for use, medical specialty, work activities, access to drugs, and substance abuse education.

Questions covering consequences of use, frequency of prescribing each of the controlled substances, and frequency of direct physical access to controlled substances in the workplace were added for the survey of practicing physicians.

Previous studies of substance use in the medical profession have focused on a single state, region, or treatment program, raising concerns

of sampling or referral bias and precluding comparisons with the main body of epidemiologic research on drug use in this country. The studies reviewed here extended the earlier survey research of McAuliffe et al on substance use among medical students, residents, and practicing physicians in one New England state.⁵⁻⁷

Medical students

With funding from the American Medical Association (AMA), the center initiated its first project in 1986—a pilot survey of 1,427 senior medical students at thirteen medical schools across the country.^{8,9} Questionnaires were anonymously administered and elicited data on demographic characteristics, use of eleven frequently abused substances, sources of knowledge about drugs, and attitudes toward drug use. Data on substance use among young adults of similar age in the general population were provided by Johnston et al.²

The results were at once alarming and encouraging. Of the 589 medical students who returned usable questionnaires, 36 percent had tried cocaine, 74 percent had smoked marijuana in their lifetime, and a substantial proportion reported having used cocaine (17 percent) and marijuana (32 percent) in the year prior to the survey. Furthermore, attitudes toward use of these substances were lenient—the majority believed that occasional use of these substances represented little or no risk to the user and should carry no negative consequences. Nonetheless, medical students reported lower rates of cocaine and marijuana use than their age and gender cohorts in the general population and were also significantly less likely to have used either drug in the year before the survey.

After further refining the questionnaire, we received support from the American Medical Association for an expanded study. This survey, conducted in 1987, covered a sample of 3,052 senior students from twenty-three US medical schools.¹⁰ Johnston et al again provided, for comparison purposes, data collected in 1987 on an age-similar cohort in the general population.³

Sixty-seven percent of the medical students surveyed responded. Significantly fewer reported ever using marijuana (66 percent) or cocaine (32 percent) than their high school graduate age peers, although medical student "lifetime ever" rates were comparable to other college graduates. Rates of cocaine or marijuana use in the year or month before the survey were, however, significantly lower for medical students than college graduates or those with only a high school education. Attitudes toward occasional use of marijuana corresponded with those expressed in the pilot survey, but the majority believed that occasional use of cocaine and other psychoactive substances (except alcohol) was of sufficient concern to warrant counseling or treatment. Over 90 percent of those who reported substance use, had begun using these substances before entering medical school. Only

for benzodiazepine tranquilizers did a substantial proportion who ever used (36 percent) begin use during medical school.

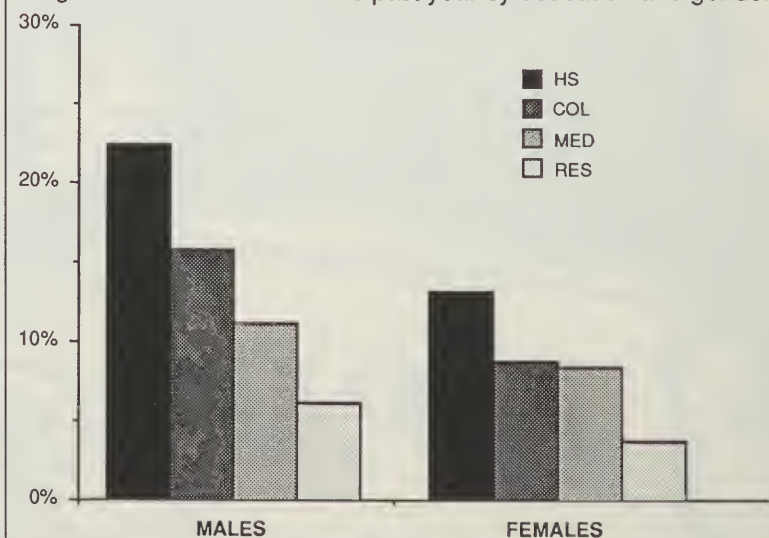
Resident physicians

In 1987, we received support from the AMA to use the same questionnaire for a study of resident physicians.¹¹ The sample for this study consisted of 3,000 third-year residents randomly selected from the AMA's master file of US physicians. The master file, which includes AMA members and nonmembers, is considered the most comprehensive list of US physicians available. Residents were asked about their use of eleven substances. For controlled prescription substances, respondents were instructed only to report use "not prescribed by another physician for a legitimate medical or psychiatric condition," thereby eliminating supervised medical use.

Sixty percent of the resident physicians surveyed responded (N=1,785). Resident physicians had lower rates of illicit substance use and higher rates of use of certain controlled prescription drugs than their nonphysician age and gender peers. But residents differed from medical students in two key ways. First, residents' rates of recent cocaine and marijuana use were much lower. Second, they were more likely to use benzodiazepines than medical students. The primary reason given for use of prescription substances was self-treatment, whereas illicit substances and alcohol were primarily used for recreation.

When medical students and residents were compared with each other and with their age and gender peers, several trends emerged. **Figure 1** illustrates cocaine use among high school and college graduates (average age: 28.6 years) surveyed in 1987 by Johnston et al,³ and medical students (average age: 27.7 years) and residents (average age: 30 years) from our 1987 surveys. Male and female residents had consistently lower rates of substance use for most substances than their age and gender peers in the general population—differences that

Figure 1 - Cocaine use in the past year by education and gender*



* 1987 surveys of medical students, residents, and high school or college graduates of similar age.

were significant for marijuana, cocaine, cigarettes, and amphetamines. Female residents were significantly more likely, however, to use alcohol and benzodiazepines than females of similar age in the general population. Male residents were significantly more likely than female residents to have tried marijuana or to smoke cigarettes, but significantly less likely to use either substance than other males of similar age. Male and female residents tended to be more like each other than their age and gender peers in their past year and past month use of six of the eleven substances.

Data on when use of the various substances was initiated revealed that most residents who engaged in substance use had initiated such use in college or earlier (Figure 2). Use of controlled prescription substances, however, suggested a different trend. A substantial proportion of residents who had ever used benzodiazepines or opiates began their use during residency.

Practicing physicians

Following the resident survey, the center received support from the National Institute of Drug Abuse for the first national survey of substance use among US physicians. The survey was performed in 1989 and 1990, and the initial results are being reviewed for publication. A preliminary review of the data suggests that practicing physicians more closely resemble medical students and residents in reporting lower rates of marijuana and cocaine use than their age and gender counterparts in the general population. Practicing physicians do, however, have a unique relationship with the controlled substances they prescribe to patients in their daily work. This relationship will be described in future reports.

Discussion

The medical students, residents, and physicians surveyed seem to fall into two general categories: (1) those who use alcohol and illicit substances for recreation and (2) those who

use controlled prescription drugs for self-treatment. Recreational use of illicit drugs and alcohol appears higher among medical students and young physicians than among those in later stages of practice. This pattern is consistent with widespread experimentation with illicit drugs by young Americans throughout the 1970s and 1980s. Our analyses of medical students, residents, and practicing physicians support McAuliffe's earlier conclusion that recreational drug use in the younger generation of physicians is greater than that of previous generations.⁵

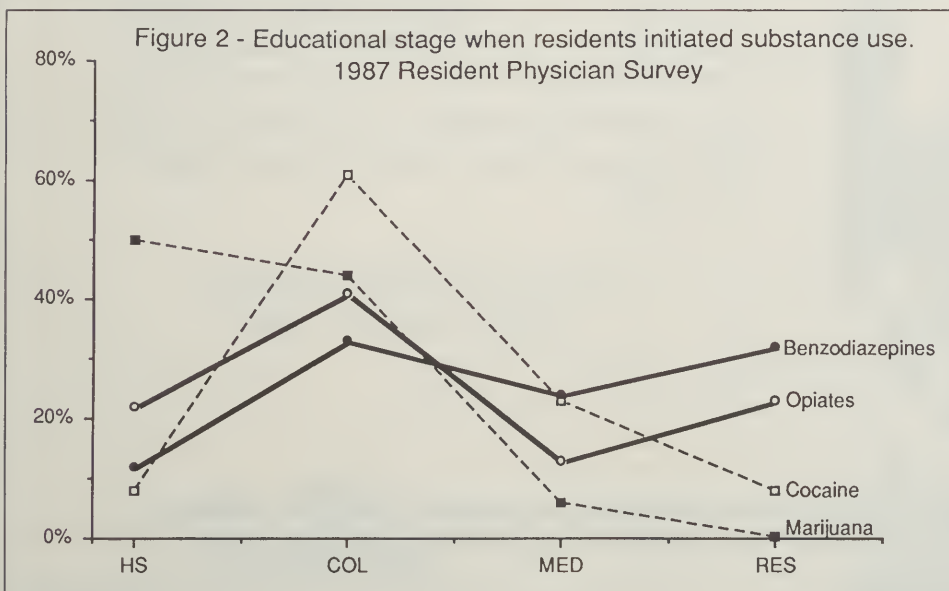
The finding that a substantial minority of young physicians initiated use of opiates and benzodiazepines during residency is disturbing for two reasons. The first is the tendency for some young physicians to treat themselves with these substances, rather than use them under the supervision of another physician. The second concern is that both opiates and benzodiazepines carry the potential of chemical dependence.

Self-treatment with controlled prescription drugs continues to occur despite longstanding warnings in the medical profession against such practice. The old adage, "the physician who treats himself has a fool for a patient," applies equally to today's physicians. The Federation of State Medical Boards of the United States takes a firm position in its model medical practice act against prescribing controlled substances to oneself or to a member of one's immediate family. Yet as of August 1991, only 50 percent of the states had a formal policy against self-treatment.¹² A few of these, including California, Florida, New Hampshire, Washington, Wisconsin, and Wyoming, have written this proscription into state law. In most other states, however, the policy was adopted through the administrative rules of the state medical licensing board.

State medical board policies vary. Some prohibit self or family treatment, some make allowances for emergencies, and others simply admonish that treatment of oneself or one's immediate family with a controlled substance could be

grounds for disciplinary action when there is suspicion of, or potential for, substance abuse. Canada's Minister of National Health and Welfare has issued a national policy directive that physicians should not treat themselves or an immediate family member with a narcotic or controlled drug "in other than an emergency situation."¹³ The policy statement calls such practice "unethical" and warns that "experience over the years has demonstrated that practitioners involved in this practice may encounter various problems that too often become uncontrollable." The authors agree that self-treatment with controlled sub-

Figure 2 - Educational stage when residents initiated substance use.
1987 Resident Physician Survey



stances places the physician at risk of substance abuse, and should therefore be avoided.

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Acknowledgments

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Relapse and recovery: Five to ten year follow-up study of chemically dependent physicians—The Georgia experience

Karl V. Gallegos, M.D.; Barry H. Lubin, M.D.;
Carol Bowers, R.N.C.D.; James W. Blevins, M.D.;
G. Douglas Talbott, M.D.; and Philip O. Wilson, M.D.

Of 100 physicians who entered into a continuing care contract during a five-year period with the Impaired Physicians Program of the Medical Association of Georgia, seventy-seven have maintained documentable abstinence from all mood-altering substances. One physician was lost to follow-up. Twenty-two relapsed, eighteen of whom have undergone another treatment for chemical dependence. Only one physician in the relapse group has been involved in a pattern of chronic relapsing behavior.

Dr. Gallegos is the director of the Division of Data and Statistics, Caduceus Foundation; Dr. Lubin is the director of Continuing Care Services for the Talbott Recovery System; Ms. Bowers is the coordinator for the Health Professionals Program; Dr. Blevins is a staff psychiatrist at Anchor Hospital and with the Talbott Recovery System; Dr. Talbott is professor of psychiatry, Emory University and founder of the Medical Association of Georgia's Impaired Physicians Program; and Dr. Wilson is the medical director for Inpatient Services, Anchor Hospital. This project has been sponsored by a grant from the American Medical Association (AMA) Education Research Foundation (ERF), and the Caduceus Foundation. Reprints: Barry Lubin, M.D., Director of Aftercare Services, Talbott Recovery System, 5448 Yorktowne Drive, Atlanta, GA 30349.

Ultimately, the most critical issue in reviewing the treatment of chemically dependent physicians is the evaluation of the effectiveness of treatment. The primary goal of chemical dependence treatment, as in other areas of medicine, is to help the patient to achieve and maintain long-term remission of disease.¹ Treatment outcomes for physicians recovering from substance abuse vary considerably, with positive results ranging from 27 percent² to 92 percent.³ Because of methodological differences in treatment and outcome structure, it is difficult to accurately categorize programs for the sake of meta-analysis.

The interpretation of treatment outcomes⁴ that specifically address recovery in the impaired physician has been hampered by a number of factors. Notable among these⁵ are differences in the population under study (reliance on inadequate or incomplete diagnostic criteria in choosing subjects for study); failure to adequately account for treatment dropouts in analysis of treatment outcome data; failure to follow patients for adequate lengths of time post treatment; and failure to provide for adequate, multidimensional treatment outcome measures that map a full range of patient behavior.

The purpose of this brief preliminary report is to (1) determine if there are specific pretreatment, demographic, professional, and/or substance abuse factors that predispose an individual to relapse; (2) define the relapse rate as a function of time; (3) describe posttreatment factors associated with relapse; and (4) present specific recovery components the

authors believe are important in the prevention of relapse among recovering physicians.

Methods

Background. In 1975, the Medical Association of Georgia (MAG) implemented its Impaired Physicians Program (IPP) statewide.⁶ Since then, more than 2,500 physicians from all fifty states and from five foreign countries have presented for evaluation and/or treatment of impairment. Research was begun in 1983 to (1) characterize the impaired physician; (2) stage the disease of chemical dependence and its recovery; and (3) provide necessary treatment process evaluation to guide the implementation of new practices into the treatment program.

This investigation was designed to determine if there are times in the course after treatment when individuals appear to be more vulnerable to relapse. Through an extensive interview process, all of the individuals who relapsed were evaluated. They were asked detailed questions about their relapse, responses to which were validated by family members and professional colleagues.

The continuing care contract. All members of the study group signed a contract that committed them to participation in a continuing care program for twenty months. Said individuals agreed to abstain from all mood-altering substances (alcohol and/or drugs) except as prescribed by their primary care physician or approved by their monitoring professional/addictionologist, and to follow a relapse contract. The relapse contract specifies that individuals who relapse must contact their Alcoholics Anonymous/Narcotics Anonymous (AA/NA) sponsor, inform their monitoring physician, and report the relapse to a member of the continuing care committee.

The continuing care contract also specifies that signees must undergo frequent, randomized, unscheduled urine drug screens; have a primary care physician who will attend to their medical needs; and have a monitoring physician who will serve as a recovery-mentor while assessing progress in recovery for the signee. Each person who enters into the contract agreed to go to a minimum of five AA or NA meetings a week, and to one Caduceus Club⁷ meeting per week. Many of these individuals also agreed to go to individual and/or marriage and family therapy when indicated. Those who had a co-morbid psychiatric illness had to agree to continue therapy with a psychiatrist and take appropriate medicines that were to be prescribed. Each individual also was allowed to create his or her own spiritual program, physical fitness program, and leisure activity schedule. There were monthly follow-up meetings to review the physician-patient's progress in recovery. Spouses or significant others were also encouraged to attend. Reports from many sources allowed the continuing care services program to evaluate an individual's recovery.

This continuing care program continues to be modified as process evaluation research indicates. The program described above was the aftercare program used during the study period. There have been numerous changes made as a result of this research.

Results

Description of the study population. Between July 1982 and June 1987, one hundred physicians who consecutively entered into a continuing care contract with the Georgia Impaired Physicians Program were included in an outcome study (Table 1). All resided in Georgia. Ninety-four had completed all phases of the Georgia Impaired Physicians Treatment Program and upon completion signed their continuing care agreement. Two did not successfully complete the full treatment process (they had a partial treatment), but were allowed to sign the contract and begin the continuing care program. These two individuals refused to continue their treatment but were not discharged from the program against medical advice. Four entered into the agreement after a comprehensive ninety-six-hour assessment. Two of these four had already successfully completed another treatment

Table 1. Demographic data

	Percent
Age (Mean = 39.0, SD = 9.9)	
<35	43
35-44	32
45-54	17
55-64	7
≥65	1
Sex	
Males	92
Females	8
Race	
White	95
African-American	5
Marital status	
Married	45
Divorced	15
Single	30
Separated	8
Widowed	2
Marital discord reported	
Yes	84
No	16
Professional activity status	
Practice	65
Resident	24
Unemployed	10
Retired	1
Specialty at time of admission to treatment	
Family and general practice	23
Anesthesia	17
Psychiatry	15
Internal medicine	12
General surgery	9
Surgical subspecialties	13
Orthopaedic surgery	5
Thoracic surgery	2
Ophthalmology	2
OB/GYN	1
Plastic surgery	1
Neurosurgery	1
Otolaryngology	1
Emergency medicine	4
Pediatrics	3
Radiology	1
Dermatology	1
Occupational medicine	1
Rehabilitation medicine	1

program and requested follow-up in the Georgia IPP continuing care monitoring system. The other two refused treatment, even though a diagnosis of addiction was established and treatment was recommended. These two individuals were convinced that they did not need treatment to stay sober, and requested follow-up in the Georgia IPP continuing care program. All one hundred physicians had completed the full recommended treatment process for chemical dependence. Although all had a primary diagnosis of chemical dependence, sixteen had a concurrent psychiatric diagnosis.

The mean age for the study group was 39 years (standard deviation=9.9). There was a statistically significant overrepresentation of young physicians and an underrepresentation of older physicians in the study group in comparison with the population of all Georgia physicians.⁸ Men constituted 92 percent of the study group as compared with 88 percent of all Georgia doctors. Five percent of the physician-patients were African-American, 95 percent were white. Women and African-Americans were proportionately represented in this sample of physicians.

Less than half (45 percent) of the physician-patients were married when they presented for treatment. Fifteen were divorced, eight were separated, and two were widowed. There was a significant prevalence⁹ of individuals in the study population who had never been married (N=30). Marital discord as a result of the chemical dependence was reported by 84 percent of those who were married, widowed, separated, or divorced.

Substance abuse patterns. Table 2 describes patterns of substance abuse. Alcohol was the drug most commonly

abused, followed by cocaine, meperidine hydrochloride, and diazepam. Polydrug abuse was frequently seen. Only twelve physician-patients reported abuse of a single substance, and for ten of these twelve, alcohol was the drug reportedly used. The younger physicians were more likely to abuse multiple substances including street drugs (e.g. THC (tetrahydrocannabinol) and cocaine). Forty-six physician-patients reported abusing drugs parenterally. Most of the study group (58 percent) had had some form of previous alcohol and drug and/or psychiatric treatment for their problems.

Practice and license status. There was a statistically significant overrepresentation of residents and unemployed physicians in the study group. Several specialties were also overrepresented including anesthesia, general and family practice, and psychiatry. Many physician-patients had serious legal and or licensing problems (Table 3) associated with their substance abuse. Only 51 percent of the total did not report a license or a criminal/legal problem.

Outcome

Seventy-seven physician-patients have maintained documentable abstinence from all mood-altering substances since the initiation of their continuing care contract. All of these individuals have successfully completed their continuing care contracts. These individuals have continued to participate in a recovery program for five to ten years after completing treatment. One of the seventy-seven died of sudden cardiovascular causes in the seventh year of recovery. All of the remaining physician-patients are currently practicing medicine, except for three who retired.

One of the original 100 physician-patients maintained documented recovery for at least three years but has since moved. This patient could not be found to update the recovery information and was counted as being lost to follow-up.

Twenty-two physician-patients have had a documented relapse. Eighteen have undergone another treatment for their chemical dependence. Of those who relapsed, one died during his relapse. All but four of the remaining physicians in the relapse group currently have had at least two years of continuous sobriety since their relapse. Of those who relapsed and are alive, all but three are currently practicing medicine. Two are retired. Only one of the physicians within the relapse study group has been involved in a pattern of

Table 2. Patterns of substance abuse

Drugs most frequently reported abused	Percent
Alcohol	71
Cocaine	21
Meperidine hydrochloride	19
Diazepam	18
Marijuana	17
Percodan	12
Fentanyl citrate	11
Codeine sulfate	9
Amphetamine	7
Route of administration	
Oral	54
Parenteral	46
Numbers of drugs abused	
Single drug	12
Multiple drugs	
2	22
3-4	37
≥5	29
Previous alcohol and drug or psychiatric treatment	
None	42
Outpatient	9
Inpatient (no. of times)	49
1	30
2	9
≥3	10
Classification of drugs	
Alcohol only	10
Alcohol and drugs	70
Drugs only	20

Table 3. License and legal status at the time of admission

State medical license status	Percent
Intact	74
Problem	26
Drug enforcement administration license status	
Intact	63
Problem	37
Criminal/legal problems	
Yes	34
No	66
Presence of either a legal and/or licensing problem	
Yes	49
No	51

continuous, chronic, relapsing behavior since the initiation of relapse; this individual is not practicing medicine.

Who relapses?

The relapse group (N=22) was compared with those who did not relapse (N=77). There was no significant difference between the two groups with respect to any pretreatment or treatment variables studied (Tables 1–3). However, all physician-patients who relapsed stated that they had stopped participating in a recovery program prior to their relapse (i.e., either they had stopped going to AA/NA meetings altogether or went infrequently).

Special attention needs to be given to the four individuals who signed a continuing care contract without successfully completing treatment. Two completed partial treatment and two refused treatment after their ninety-six-hour assessment. All of these individuals relapsed within twelve months of signing their aftercare agreement.

Eleven physician-patients relapsed in the first year after completion of treatment. Four relapsed in their second year.

Approximately 68 percent (15 of 22) of all those who relapsed, did so before completing their two-year continuing care contract. Two patients relapsed in their third year. In the population studied, the incidence of relapse (Figure) seems to taper off after the third year. Only one physician-patient relapsed in years four, five, six, seven, and eight of their recovery. To date, no one has relapsed in their ninth or tenth year of recovery.

When those who relapsed were questioned extensively about the stressors in their lives that may have precipitated their relapse, several factors emerged as possible risk factors for relapse (Table 4). In general terms, those who relapsed within the first year of signing an aftercare contract were more likely not to believe the disease concept. They were more likely to believe that they did not need the recommended help. In spite of the threat of loss of advocacy from the program and in spite of knowledge that they were being scrupulously monitored, these physician-patients believed they would not run into difficulties.

Family and emotional issues frequently triggered relapse in those who relapsed after the second year of recovery. In virtually all cases, relapse began with behavioral dynamics that reactivated their denial of their condition and isolation, elevated their stress, and impaired their judgment. Each individual slowly stopped going to AA/NA meetings. There is no evidence that fear of losing a license to practice medicine or any other legal, marital, or professional sanction could inhibit a relapse or promote recovery.

Discussion

Recovery from the disease of chemical dependence is a continuous process, although only a few theorists¹⁰⁻¹³ have recognized the importance of examining abstinence as part of the total process of chemical dependence. Research to refine our understanding of specific risk factors for relapse and ways to prevent these factors are needed. Indeed, preventing relapse is the fundamental issue in addiction treatment today. Physicians who relapse can have a significant impact on themselves and their families, and also on the patients they serve and on the medical profession. Investigation into reducing the potential for relapse in recovering physicians (and other health professionals) is urgently needed.

The continuing care program sponsored by Talbott Recovery System, a private treatment program that works with the Impaired Physicians Program of the Medical Association of Georgia, has evolved over the course of several years and was developed to facilitate, reinforce, and maintain an individual's decision to stop drinking and/or using drugs. By the criteria and philosophy of the continuing care plan, physician-patients are responsible for their own recovery; they are held personally accountable. When physician-patients follow the continuing care plan, the advocacy of the program is granted. This kind of contingency contract appears to be very effective.

Physician-patients who have the most success in maintaining their recovery understand the need for AA/NA meetings and attend regularly. They use their sponsor to discuss issues of importance in their lives. Such individuals gladly use their

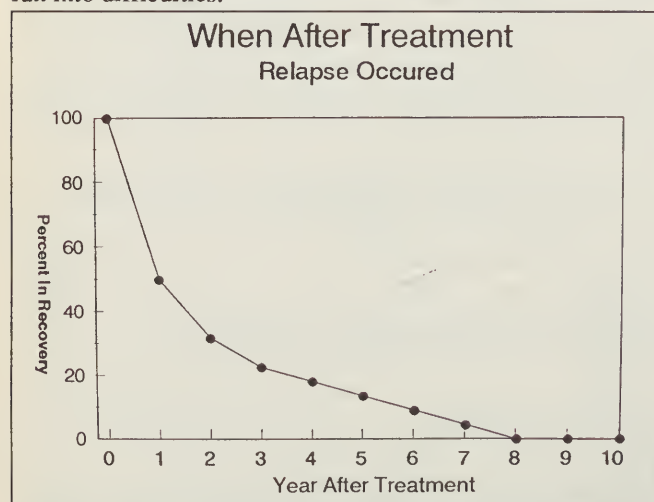


Figure. The time course of first relapse-after-treatment events in the population of physician-patients studied.

Table 4. Factors that contribute to relapse

1. Failure to understand and accept the disease.
2. Denial or loss of control.
3. Dishonesty, usually taking the form of reality distortion and emotional concealment.
4. The dysfunctional family.
5. The lack of a spiritual program.
6. Stress, and the inability to cope with stress.
7. Isolation, and failure to become an active member of AA and/or NA.
8. Untreated secondary addictions (e.g., food, sex, work).
9. Cross-addiction.
10. Holiday Syndrome (increased probability of relapse during holidays).
11. Withdrawal.
12. Overconfidence.
13. A return to drinking or using friends and old habits.
14. Guilt over the past.
15. Medical problems.
16. Not successfully completing treatment.
17. Poor "continuing care" monitoring.

monitoring physician as a professional mentor to discuss problems related to recovery and the practice of medicine.

Central to the philosophy of AA is the concept of a higher power,¹⁴ as discussed at length in *The Big Book of Alcoholics Anonymous*. The authors feel a spiritual program, such as the one promoted by AA, is an essential ingredient of recovery.

Physician-patients who are most successful in their recovery avoid emotions such as anger, guilt, depression, anxiety and insomnia by using the program's principles.¹⁵ Physician-patients also must avoid compulsive behavior (e.g., sex, work, food, shopping, nicotine, gambling, theft, speeding). These physician-patients realize the importance of becoming skillful in participating in important relationships (family, sponsor, significant-other, spouse, parents, children, and friends). They learn to work on the dysfunctional aspects of relationships and improve on the positive parts of friendships. Isolation is most often a key symptom of the disease of chemical dependence. Recovery demands "re-people-ization."

Physical health, exercise, rest, and leisure time are also important parts of a recovery program. Physicians learn early about the work ethic. However, recovery requires that the recovering physician-patient set priorities. Physicians who appear to do the best in their recovery develop a profound and abiding attitude of gratitude. They learn to have open and honest communication with family members. They are regular in their attendance at AA/NA and continuing care meetings. They communicate regularly with their sponsor, take a daily inventory, and check out their behavior with trusted family members and recovering friends. These behaviors must become a normal part of the recovering physician's life.

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Glossary

The lack of precise definitions and universal agreement on language has hampered effective communication among professions.¹⁵ For the purpose of this presentation, we provide selected nomenclature as defined by the American Medical Association's (AMA's) Council on Scientific Affairs (CSA) Panel on Alcoholism and Drug Abuse.¹⁶

Abstinence: Cessation of use of a psychoactive substance previously abused or upon which the user has developed drug dependence.

Chemical Dependence: Generic term relating to psychological or physical dependence, or both, on an exogenous substance.

Recovery: A process of overcoming both physiological and psychological dependencies on a drug or on alcohol.

Rehabilitation: The restoration of an optimal state of health by medical, psychological, social, and peer group support for a chemically dependent person and his or her significant other.

Relapse: Recurrence of alcohol or other drug dependent behavior in an individual who has previously achieved and maintained abstinence for a significant time beyond the period of detoxification.

Sobriety: Generally refers to the state of complete abstinence from alcohol and other drugs of abuse in conjunction with a satisfactory quality of life.

Treatment: Application of planned procedures to identify and change patterns of behavior that are maladaptive, destructive

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The Impaired Physician Program of the Medical Society of the District of Columbia

Donald C. Meek, M.D.

Dr. Meek is chairperson of the Medical Society of the District of Columbia Physician Health Committee.

The Impaired Physician Program of the Medical Society of the District of Columbia was established in 1980. Although the society maintained very active peer review programs prior to that time, it became clear that some of the physicians who were being seen in the peer review committees were ill and were not well-served in a disciplinary milieu. Concurrently, the American Medical Association (AMA) was also encouraging and assisting state medical societies in the development of impaired physician programs. A November 1972 report of the AMA Council on Mental Health stated that "(I)t is a physician's ethical responsibility to take cognizance of a colleague's inability to practice medicine adequately by reason of physical or mental illness including alcoholism or drug dependence."¹ After a modest start, the DC program came into its own in 1983 when Martin J. Valaske, M.D. became chairperson of the Impaired Physician's Committee. Under Dr. Valaske's leadership, the program developed into one that not only accepted cases that came to its attention, but sought to identify those that had not yet surfaced.

Funding for the program has improved gradually over the years. Initially supported strictly by general society dues, program funding has been augmented at various times by a special dues assessment and contributions from the Medical Society and Auxiliary Foundation. In 1989, the District of Columbia Hospital Association made a contribution on behalf of Washington, DC-based hospitals. Additional sources of funding continue to be sought from those agencies and institutions that benefit from the existence of the program, particularly in light of the fact that the program serves both members and nonmembers of the medical society.

How it works

The Physician Health Committee, comprised of twenty-four practicing physicians, has primary responsibility for the Impaired Physician Program. The committee chairperson acts as director of the program and answers to the society's executive board; two full-time staff members, who are responsible for the society's peer review activities, handle the day-to-day functioning of the program. Expressions of concern regarding

Since its establishment in 1980, 128 physicians have been referred to the Impaired Physician Program of the Medical Society of the District of Columbia, of whom sixty-four have either successfully completed the program or are in stable recovery.

the health and well-being of any physician practicing in the District of Columbia are accepted from any source. Although callers are asked to identify themselves, the names of reporters and the contents of reports are confidential. Once a report is received, efforts are made to discreetly verify its accuracy. If sufficient evidence exists that there may be a problem, an intervention is arranged. Interventions are a highly specialized process of getting through the physician's ever-present denial and getting the physician to agree to an initial evaluation or to treatment if there is agreement that a problem exists. Participants in the intervention include appropriate representatives of the Physician Health Committee and sometimes members of the physician's family. The ultimate goal of the process is to have the physician go for an evaluation immediately following the intervention, and arrangements for the evaluation are made in advance of the meeting. In some cases, it is determined that no impairment exists and the case is closed without prejudice to the physician.

If the existence of an impairment is confirmed and treatment guidelines are established, the physician signs an agreement with the program. Program participants generally agree to abstain from use of all mood-altering substances, to obtain urine screening, to attend self-help groups, and, for those suffering from chemical dependence, to complete an annual continuing medical education (CME) requirement on substance abuse. Participants also agree to obtain appropriate treatment, to meet monthly with a monitor assigned to them from the Physician Health Committee, and to permit open communication with the chief of staff where they hold hospital privileges or with other employers. Those physicians suffering from physical or psychiatric problems other than substance abuse sign appropriately tailored agreements. Agreements are typically for a five-year period. If an immediate diagnosis is not possible, the physician may be placed under a monitoring agreement for a period of time until a diagnosis can be established.

Physicians who come under the supervision of the program frequently have problems with their malpractice insurance carrier, hospital credentials committee, or licensure board. In addition to identifying, assisting, and monitoring impaired physicians, a key function of the program is to advocate for those physicians who are in compliance with the terms of their agreement and are in solid recovery. In addition to the desire to be helped, it is this aspect of the program that most frequently draws physicians into the program.

Experience

Since its inception in 1980, 128 physicians have been referred to the Impaired Physician Program. **Figure 1** shows referrals on an annual basis. Of these 128 physicians (**Figure 2**), twenty-six have successfully completed the terms of their agreement with the program. Thirty-eight of these physicians are currently under active monitoring with the program. Seven physicians remain under investigation. The no action category, which contains thirty-four physicians, includes those situations in which no impairment could be identified

or substantiated, the impairment did not have an impact on patient care, or the matter was more appropriately handled by an impaired physician program in another state. Five of the physicians died of their disease, and six were encouraged to cease practice, usually because of advanced age. In twelve cases, the program withdrew its advocacy because of the physician's failure to cooperate. These cases were either reported to the Board of Medicine or to another responsible entity such as a medical school dean in the case of a medical student.

Figure 3 reflects the distribution by age of those physicians in whom an impairment was found. The cases confirmed by the program include drug/alcohol addiction (81 percent), psychiatric problems other than drug/alcohol addiction (13 percent), and physical problems that impaired functioning (5 percent). Thirty-five percent of the addicted were alcoholic and 43 percent were drug addicted. Of the drug addicted, their drugs of choice were as follows: cocaine, 35 percent; poly-drug addicted, 35 percent; Percodan, 8 percent; butalbital, 4 percent; amphetamines, 3 percent; heroin, 3 percent; opiates, 3 percent; Fiorinol, 3 percent; Dilaudid, 3 percent; and fentanyl, 3 percent.

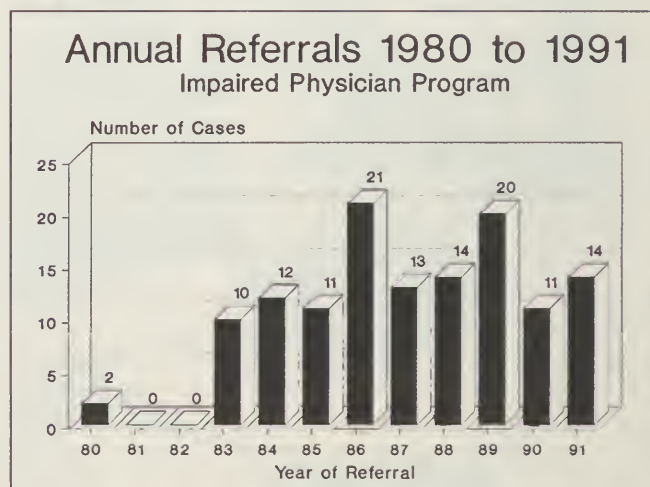


Figure 1.

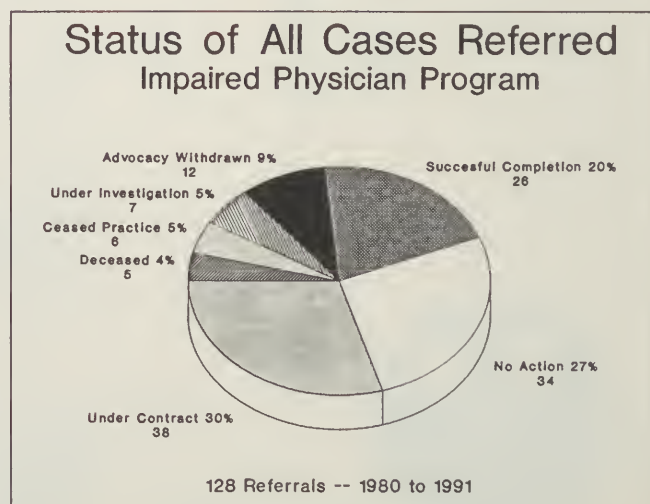


Figure 2.

Reporting sources included twenty-nine institutional referrals, usually hospitals. There were ninety-one personal referrals; personal referrals include self-referrals and referrals by colleagues, spouses, coworkers, and patients. Three referrals came from the legal system. **Figure 4** illustrates the gender distribution in which eighty-seven of those physicians found to be impaired were male and fourteen were female. The distribution among the medical specialties is reflected in the **Table 1**.

Conclusion

Acceptance of the District of Columbia Impaired Physician Program has improved dramatically since its inception. Physicians have become much more willing to self-refer because of the positive comments they have heard about the program's success rate (**Figure 5**). Being a program partici-

pant has also become somewhat less stigmatizing. There is an increased willingness to grant licensure, privileges, or employment to those physicians who may have had a problem, but who are now in solid recovery and under strict monitoring.

Hospitals are making more and more referrals, and they, as well as licensure boards, are relying on the program to monitor physicians on their behalf and provide periodic reports.

Hospitals have also provided funding for the program, which we take as a significant vote of confidence.

The program relies heavily on the reports of others in identifying physicians who may need assistance. Do you suspect that a colleague practicing in the District of Columbia may be impaired? If so, please call for confidential assistance. We can be reached at (202) 466-1800 during business hours and at (202) 466-1809 at all other times. Ask for the Impaired Physician Program.

Reference

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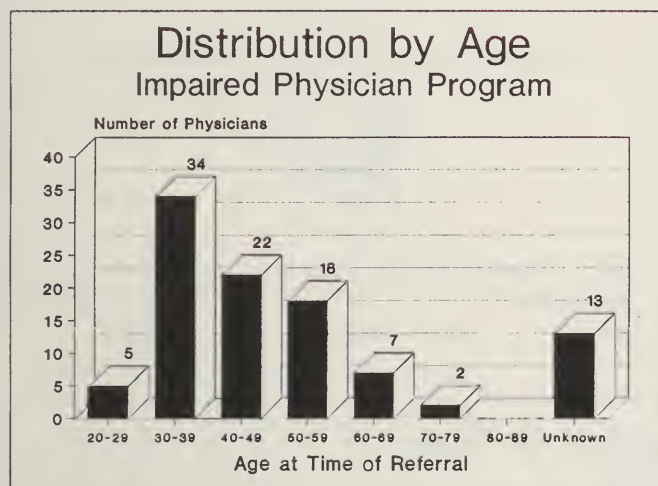


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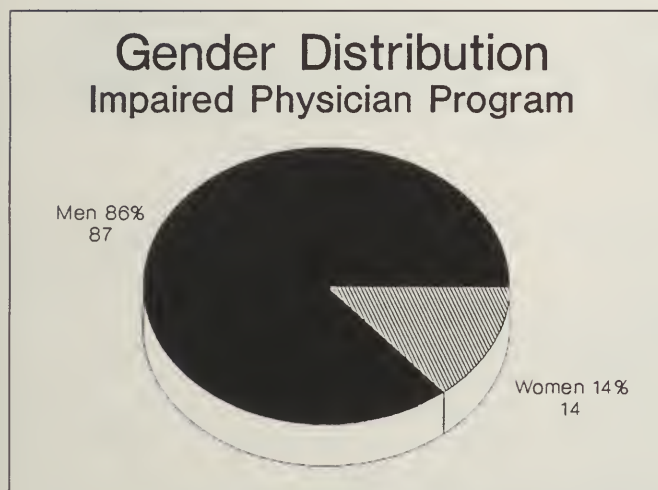


Figure 4.

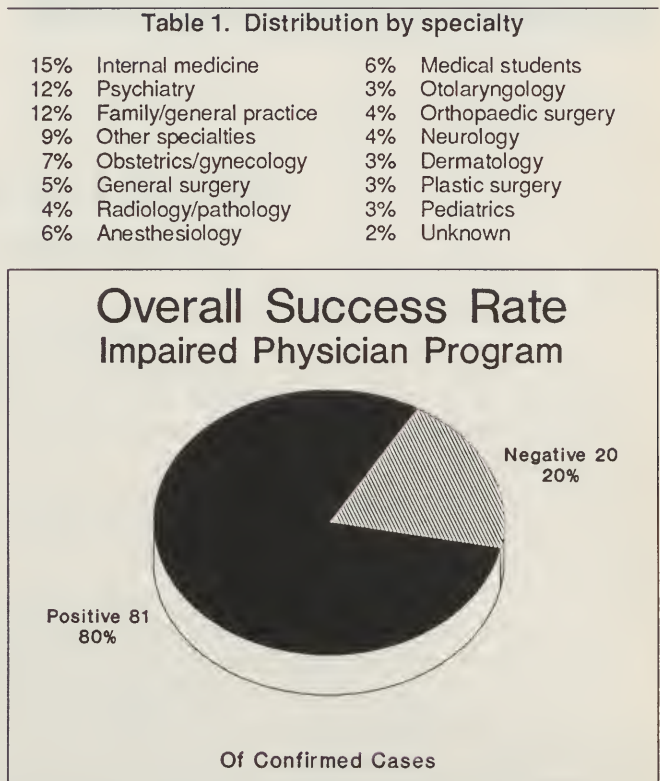


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Nine years experience with chemically dependent physicians: The New Jersey experience

Edward G. Reading, M.Div., NCAC II

Reverend Reading, a Roman Catholic priest of the Diocese of Paterson, is assistant director, Physicians' Health Program of the Medical Society of New Jersey, and secretary, Board of Directors of the National Federation of State Physicians Health Programs.

Few studies have been able to retroactively evaluate the effectiveness of treating chemically dependent physicians. This paper provides an overview of the Physicians' Health Program of the Medical Society of New Jersey; details the current status of physicians treated for chemical dependency from 1982 to 1990; lists the perceived reasons for successful recovery; and identifies the needs for the future.

The Physicians' Health Program of the Medical Society of New Jersey was originally established as a volunteer impaired physicians committee in 1976. In September of 1982, the medical society realized that a volunteer committee program was inadequate to appropriately deal with the problem of physician impairment. A full-time medical director was hired with secretarial staffing. Dr. David I. Canavan was the first full-time medical director of a state medical society impaired physicians program. In 1988, the name of the program was changed from the Impaired Physicians' Program to the Physicians' Health Program (PHP) for functional and political reasons.

The categories of programmatic involvement offered by the PHP include services to any physician who lives, works, or is licensed in New Jersey (including M.D., D.O., V.M.D./D.V.M., and D.P.M.), New Jersey medical students, and physicians' family members. Resident physicians are provided the same services as other program participants, although special considerations are made during this level of training to accommodate their schedules. Some of these accommodations include having PHP staff visit resident physicians at their hospital during times when the residents will not be required to be at rounds or lectures and arranging for urine monitoring in the resident physicians' hospital rather than at a location that would require travel.

Confidentiality is offered to all program participants under the umbrella of the federal regulations on confidentiality of alcohol and drug abuse records (42 CFR Part 2). The only exception to this procedure is if a physician is actively impaired *and* is continuing to practice and is refusing appropriate treatment. If a physician is in monitored recovery and is not a danger to patients, the program follows the federal regulations, which forbid the program from disclosing information unless there is a signed release or a court order. A subpoena for information cannot force the program to release information.

The treatment and recovery orientation of the PHP rather than the

disciplinary and control orientation of the State Board of Medical Examiners may explain why the majority of the PHP's referrals for the past nine years have been from colleagues (over 50 percent), self-reports (20 percent), or from family members (15 percent). Very few of our referrals have been initiated by the State Board of Medical Examiners. The state board tends to identify late-stage impaired physicians whose dysfunctional behavior is symptomatic of their disease. The vast majority of PHP participants are not known to the board. In most of our program participants, the disease was arrested during early or middle stages, and professional impairment was not a factor even though individuals may have been personally impaired. By the time the professional impairment is identified by the State Board of Medical Examiners or the Drug Enforcement Agency (DEA), many physicians have already been in recovery for one or more years. The bureaucratic lag-time gives a chance for recovering physicians to document ongoing recovery prior to appearing before the board.

Over the course of the past nine years, 90 percent of PHP participants have been male and 10 percent female. The division of program participants by medical degree is seen in Table 1. Table 2 summarizes the variety of presenting diagnoses at the time of intake.

Treatment

The PHP uses a variety of treatment modalities for chemically dependent physicians contingent upon individual circumstances. The modalities include

1. twelve-step self-help groups (which are based on the Alcoholics Anonymous model) as either primary treatment (usually for early-stage dependency) or as part of ongoing care after primary treatment;

Table 1. Program participants by medical degree

Degree	Number	Percent
M.D.	492	83.7
D.O.	41	7.0
V.M.D./D.V.M.	13	2.2
Other	42	7.1
TOTAL	588	100.0

*Includes DPM, family members and others.

Table 2. Presenting diagnosis at time of intake

Diagnosis	Number	Percent
Alcohol only	144	24.5
Primary alcohol + Other	54	9.2
Total alcohol	198	33.7
Drug only	131	22.3
Primary drug + Other	67	11.4
Total drug	198	33.7
Psychiatric only	129	21.9
Primary psychiatric + Other	16	2.7
Total psychiatric	145	24.6
Dementia only	14	2.4
Physical only	21	3.6
Other	12	2.0
TOTAL	588	100.0

2. structured outpatient care as primary treatment or as posttreatment aftercare (when used as primary treatment, it is usually an intensive outpatient program);
3. medical detoxification as primary treatment, provided it is followed up with outpatient or residential treatment;
4. short-term residential treatment (4–6 weeks) followed by aftercare and self-help groups;
5. long-term residential treatment (4–12 months) for those experiencing multiple relapses;
6. structured halfway-house treatment, which is an alternative to long-term residential care; and
7. individualized counseling by PHP staff, plus twelve-step self-help group participation. Because this is an informal approach to treatment and recovery, the medical director must give approval for this modality to be used as primary treatment.

Individualized treatment planning allows for a wide variety of treatment options. PHP staff establish the minimum levels of treatment intensity. If a relapse occurs, a more intensive level of treatment is prescribed.

An important treatment consideration is that of third-party coverage. Some physicians do not carry health insurance, making it difficult to procure the optimal treatment. Other physicians, usually those employed in corporate medicine, are covered by health maintenance organizations, making it difficult or impossible to get appropriate treatment paid for by the third party. The PHP has developed a treatment loan fund and a grant fund to assist physicians who do not have appropriate or adequate third-party coverage.

Most physicians are treated in programs that are not physician-only programs. Physicians usually do well in treatment with nonphysicians. Integrated treatment programs allow physicians to focus on their primary disease rather than emphasizing their professional training. There are instances, however, when physician-only programs are valuable, such as in cases when a physician has multiple relapses, or when a physician is unable to separate his or her personal identity from his or her professional identity.

Current status of recovery

A survey of the current status of physicians who participated in the PHP during its first nine years was completed September 6, 1991. The survey included only those physicians with a primary diagnosis of chemical dependency. We did include those who had moved out of state and who

1. had stable recovery at the time of transfer to the other state;
2. continued to be monitored by the PHP or the state licensing board, and for whom we received periodic reports concerning recovery and relapse; and
3. periodically returned to New Jersey to visit the PHP or keep some telephone contact with the PHP (self-report).

The survey specifically excluded

1. those with a significant dual diagnosis that required more complicated treatment and recovery plans;

2. those who had died before the conduct of the survey; and
3. those who were initially referred for chemical abuse but who
 - a. were found not to be chemically dependent (e.g., no formal diagnosis was made);
 - b. were found to have a different diagnosis than the presenting problem; or
 - c. for whom we had inadequate and inappropriate information or misinformation; and
4. those who were lost to follow-up.

Limitations and shortcomings

This survey was not a scientific study but simply a survey based on clinical experience. The PHP's experience of relapse is based on the following:

1. **Self-report of alcohol/drug use.** (In this survey, we have not distinguished between a slip and a relapse.)
2. **Positive urine test result** based on random urine screens conducted within twenty-four hours of notification. The normal protocol includes eight to ten random screens per month for the first six months; six to eight random screens per month for the second six months; and four to six random screens per month for the next twelve months. After the second year, frequency is reduced to two times per month; quarterly; two times per year; and one to two times per year, based on the decision of the medical director. Random urine testing is done with clients having a history of drug use other than alcohol.
3. **Reports from others** that require verification by the PHP staff. These reports may come from family, employers, coworkers, or others.

Two-year follow-up

After two years of program involvement (Table 3), we have seen a recovery rate of 83.8 percent with no relapses. If we include those who had one relapse (13.8 percent), we see a success rate of 97.5 percent. It should be noted that in the field of chemical dependency treatment, a posttreatment re-

lapse is not unusual. It is often considered helpful to long-term sobriety and recovery.

Nine-year follow-up

The nine-year follow-up survey results (Table 4) show 73.8 percent of the physicians had no known relapses and 12.6 percent had only one relapse. Using a commonly held principle that one relapse can be helpful to long-term recovery, we see that, overall, 86.4 percent of physicians can be considered successfully rehabilitated with no relapses or only one relapse. Every year showed better than an 80 percent success rate, with the exception of 1984 (76 percent), if we include the one-relapse experiences over the course of the nine years.

Multiple relapses

It should be noted that due to close monitoring, those with two or more relapses (less than 14 percent) have been confronted about their relapse, have had their treatment intensified or reinstated with renewed intensive monitoring, and have been returned to the ranks of practicing physicians. It is a rare experience for PHP to have program participants who experience multiple relapses necessitating permanent revoca-

Table 3. Two-year follow-up

	1989	1990*	Total
Total intakes	80	65	145
Chemical dependency intakes	42	38	80
No known relapse	32 (76%)	35 (92%)	67 (83.8%)
1 known relapse	8 (19%)	3 (8%)	11 (13.8%)
2 known relapses	0	0	0
3 known relapses	2 (5%)	0	2 (2.4%)
0 & 1 relapse	40 (95%)	38 (100%)	78 (97.6%)

*The last three months of intakes in 1990 were between one and three months short of one full year of program involvement at the time of this survey.

Table 4. Nine-year follow-up

	1982*	1983	1984	1985	1986	1987	1988	1989	1990**	Total
Total intakes	48	81	60	83	76	56	52	80	65	601
Chemical dependency intakes	32*	35**	33	42	33	29	24	42	38	308***
No known relapses	18 (66.6%)	21 (66.3%)	23 (70%)	29 (69%)	24 (73%)	22 (76%)	18 (75%)	32 (76%)	35 (92%)	222 (73.8%)
1 known relapse	4 (14.8%)	6 (18.1%)	2 (6%)	7 (17%)	3 (9%)	2 (7%)	3 (12.5%)	8 (19%)	3 (8%)	38 (12.6%)
2 known relapses	3 (11.1%)	3 (9.1%)	1 (2%)	1 (3%)	0	0	0	0	0	9 (3%)
3 known relapses	2 (7.4%)	3 (9.1%)	7 (21%)	5 (12%)	5 (15%)	5 (17%)	3 (12.5%)	2 (5%)	0	32 (10.2%)
0 & 1 relapses	22 (81.5%)	27 (81.8%)	25 (76%)	36 (86%)	27 (82%)	24 (83%)	21 (87.5%)	40 (95%)	38 (100%)	260 (86.4%)

* Program began September 6, 1982 (only 4 months of intakes).

** The last 3 months of intakes were 1-3 months short of a full year of program involvement at the time of this survey.

+ Five of the 32 were not included in this survey (deceased, treatment refused, or currently out of medicine).

++ In 1983, 2 of the 35 were not included in this survey (deceased, treatment refused, or currently out of medicine).

+++ The total of chemically dependent intakes includes the 7 from 1982 and 1983 who were not included in this survey.

tion of license due to active chemical dependency. There may, however, be suspension of practice during extended residential treatment (four months to one year) or during posttreatment so as to document abstinence and recovery. These cases are almost always monitored by the State Board of Medical Examiners. In all cases, physicians who have active chemical dependency and attempt to practice medicine while refusing treatment and monitoring will be reported to the State Board of Medical Examiners with a recommendation for license suspension until recovery is adequately documented.

Reasons for high success rate

The reasons for such a high rate include

1. formal, structured, outpatient aftercare counseling (post-inpatient treatment) that continues for one to two years in most cases;
2. a highly structured urine monitoring program, which is used to identify early relapse and document abstinence; and
3. personal/face-to-face contact with PHP staff. (During the first year, there is a minimum of monthly visits, followed by every other month visits during the second year. During the third year, there are visits every third month; during the fourth year, every four months; and during the fifth year, every six months, after which annual visits are the norm as long as the physician is practicing or living in New Jersey.)

The personal visits with the PHP staff provide a number of benefits. Among them are

1. The development of a personal relationship with someone who can be perceived as an advocate and friend as well as monitor. (Appearances before the State Board of Medical Examiners include one of our staff, with documentation of recovery, literally sitting beside the physician.)
2. The provision of a person other than the aftercare counselor to whom the physician can complain when conflicts arise. (In this case, a PHP staffperson may act as a mediator of treatment disputes or the equivalent of a patient advocate. It should be noted that physicians are not permitted to unilaterally withdraw from treatment; the approval of the PHP is necessary for the termination of treatment or for the changing of aftercare therapists.)
3. The provision of regular monitoring of treatment and recovery plans. (The PHP staff make sure self-help group meetings are actively included in the recovery plan as well as in the formal therapy.)
4. Ongoing assessment of the case and updating of the treatment plan, including the easing-up or tightening-up of the recovery plan.
5. The opportunity for staff to visit with the program participant in an environment comfortable to the physician (e.g., office, hospital, coffee shop, diner, home).
6. The opportunity for timely crisis counseling on critical issues related to ongoing recovery, especially after formal counseling has been terminated.

Comparative studies

Finney and Moose¹ published a ten-year study of 113 general population alcoholics who were interviewed two years after treatment and again eight years after treatment. The study's definition of remission included not being re-hospitalized or missing work because of alcoholism in the two years prior to the study. To be considered in remission, study participants had to have drunk less than 3 ounces per day on average and less than 5 ounces per drinking day in the previous month. Additionally, they had to have had no drinking-related problems in the previous year except for family arguments. It should be noted that this study did not expect abstinence nor require an aftercare treatment plan. Based on this concept of remission, 57 percent were in remission two years after treatment, and 46 percent were in remission between two and six years after conclusion of treatment. If we were to exclude those who had returned to drinking, the remission rate would be significantly lower.

A more relevant study conducted at the Mayo Clinic compared physicians and nonphysicians after a more traditional four-week, abstinence-oriented program that included a recommendation for twelve-step self-help support groups.² In this study, the researchers found that after two years, the recovering members of the population studied showed an abstinence rate of 83 percent. The study further divided the physician population by chemical of abuse. Those who had been dependent on alcohol had a recovery rate of only 83 percent. Those dependent on drugs other than alcohol had a recovery rate of 94 percent. Those who were dependent on alcohol and other drugs (mixed dependencies) experienced a success rate of only 62 percent. On average, the physicians in this study had a success rate of 83 percent two years after initial treatment. The nonphysicians in the survey experienced an average recovery rate of 57 percent.

The New Jersey survey described in this paper (Table 3), showed a no-relapse rate of 83.3 percent at two-year follow-up. If the one-relapse cases are included, the success rate rises to 97.6 percent. Table 5 compares these three studies.

Successful treatment of chemical dependency in the general population as well as within special populations is in need of a common definition. The New Jersey survey described successful cases based upon known relapses as they relate to the use of mood-altering drugs. Relapses were determined by self-reports (which are reliable only among those who do self-report; self-reports are far from ideal if denial is active); reports from others such as family and coworkers (which are

Table 5. Comparison of two-year success rates

Study	Nonphysicians	Physicians
Ten-year study of 113 general population alcoholics ¹	57%	Not surveyed
Mayo Clinic study comparing physician and nonphysician substance users ²	62%	83%
Nine-year study of physicians in New Jersey's Physicians' Health Program	Not surveyed	83.8% (no relapse) 13.8% (1 relapse) 97.6% (total)

reliable only to the degree that denial has been broken in the family and in the professional community); urine monitoring, which is the most objective documentation available when done properly (random and witnessed); and staff assessment. While the New Jersey survey used both subjective and objective tools, all have their shortcomings.

Due to lack of research staff, we have only been able to do a survey of the current status of our physician-clients. A more comprehensive study should include the following:

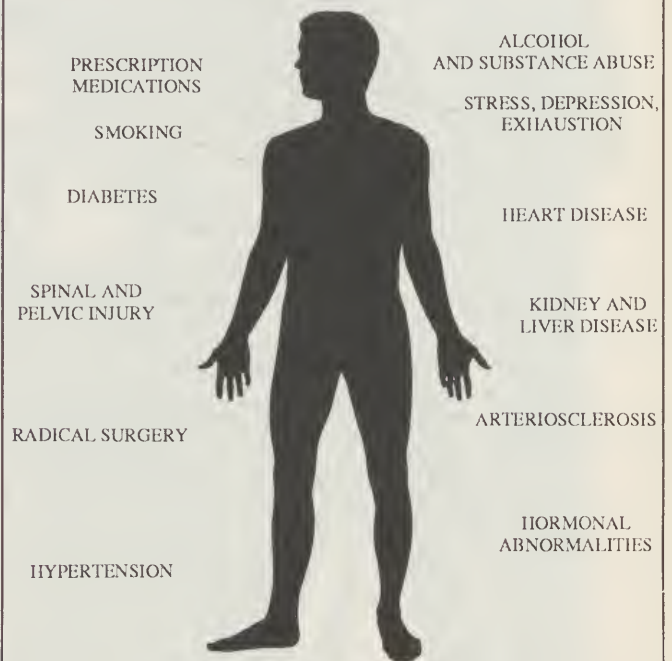
1. assessment of family health and stability;
2. assessment of professional performance since treatment (This should not be considered a function of the PHP since programs are not and should not be responsible for professional competence; but successfully recovering physicians should maintain at least professionally acceptable levels of competence. This assessment could include ongoing education and certification by specialty boards.);
3. client self-evaluation of recovery status (physical, emotional, social, professional, spiritual);
4. drug testing, not only random witnessed urine screening, but possibly the use of hair analysis (once its validity has been verified);
5. assessment of the physician's ability to balance professional, personal, and family life; and
6. recovery assessment by an independent medical professional not affiliated with a treatment center.

It is important to recognize that health recovery cannot be limited to abstinence from mood-altering drugs, although this is one major component. Assessment of successful recovery must be addressed by both subjective and objective methods that include the internal (client self-perception of treatment and recovery) and the external evaluative tools listed above.

References

1. Finney J, Moose R. The long-term course of treated alcoholism. JAMA 1991; 52:44-54.
2. Morse RM, Martin MA, Swenson WM, Niven R. Prognosis of physicians treated for alcoholism and drug dependence. JAMA 1984; 251:743-46. ■

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A#

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Brief Summary. Consult the package insert for complete prescribing information.

Indications and Usage: 1. *Active duodenal ulcer*—for up to 8 weeks of treatment at a dosage of 300 mg h.s. or 150 mg b.i.d. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a dosage of 150 mg h.s. at bedtime. The consequences of therapy with Axid for longer than 1 year are not known.

3. *Gastroesophageal reflux disease (GERD)*—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

Contraindication: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H₂-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H₂-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix[®] may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information). A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

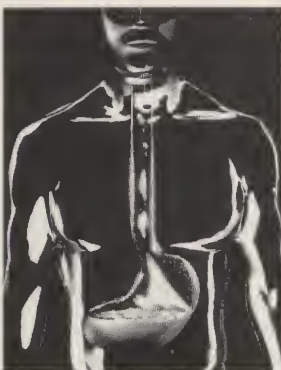
Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method. PV 2093 AMP [101591]

Additional information available to the profession on request.

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Postoperative follow-up of patients with colorectal cancer

The goal of a follow-up program after curative surgery should be to look for second primary tumors or metastatic disease by using those testing modalities that detect disease in its earliest state, presumably when it is more likely to be cured by intervention. The decision to use a particular test or group of tests after curative surgery for colorectal malignancies has become more difficult with the advent of new modalities ranging in technological complexity from history and physical examination to imaging studies. Naturally, there is also a wide range of costs associated with these various tests that must also be taken into account. Thus, in developing a follow-up program, one must account for the biologic behavior of the disease as well as the sensitivity/specificity of the various testing modalities. Historically, one of the earliest approaches to an organized follow-up was promoted by Wangensteen in 1951 who suggested routine second-look laparotomies. However, the yield from these procedures was low and the procedure was abandoned.

In a prospective study of sixty-six patients at high risk for recurrence after resection of colorectal malignancies at the National Cancer Institute (NCI), Sugarbaker and coworkers¹ used a battery of tests including history and physical examination, carcinoembryonic antigen (CEA) level, computed tomography (CT) scan of the abdomen, full lung tomography, liver/spleen scintigraphy, intravenous pyelogram, barium enema, and bone scintigraphy. With a mean follow-up of 4.5 years, they documented thirty-three patients with recurrent disease. CEA assay was found to be the most useful study, being the first positive test in 67 percent of patients with recurrence. Physical examination was the first positive test in another 21 percent of patients with recurrence. The researchers also found that 60 percent of all recurrences were at more than one anatomic site at the time of diagnosis. Only 15 percent of patients with recurrence had isolated distant metastatic disease, with just 3 percent having an isolated pulmonary recurrence. In this study, 85 percent of patients with recurrent disease were diagnosed within thirty months of their primary operation. The researchers concluded that the most useful postoperative tests are limited to history and physical examination and CEA assay. Other workers² have carefully reviewed the literature, concluding that CT scan of the abdomen, chest x-ray, intravenous pyelogram, barium enema, liver scintigraphy, fecal occult blood tests, and liver function tests have an extremely low yield and are not necessary in the follow-up of patients after resection of colorectal malignancies. In the NCI study,¹ fecal occult blood tests and liver function tests did not detect recurrence in any patient.

History and physical examination should be thorough, including special attention to symptoms such as sacral pain, urologic complaints, and vaginal bleeding. Symptoms of bone pain, altered bowel habits, and weight loss are also important.

Physical examination should be directed at identifying supraclavicular adenopathy, abdominal masses, and organomegaly.

CEA assay is the other important component of the follow-up program. A rising CEA level was found to signal recurrent disease an average of 2.5 months earlier than clinical findings.² CEA data are being evaluated in new ways, including looking at the rate of rise (slope) of CEA as a way to predict which patients truly have recurrent disease. In addition, a benefit has been reported from checking CEA levels every one to two months compared with less frequently.² It must be remembered that not all tumors produce CEA, which explains an overall 40 percent sensitivity in patients with primary lesions. The sensitivity is related to the stage of disease; CEA assay in patients having stage IV disease (Dukes D) is 85 percent sensitive. The specificity is decreased by the fact that a number of disease states can lead to an elevated CEA, including breast tumors, other gastrointestinal malignancies, and a number of benign conditions such as renal failure, biliary disease, and tobacco abuse. It must also be remembered that a normal CEA does not exclude the possibility of persistent disease, local recurrence, or distant metastatic disease.²

Colonoscopy is an important part of the follow-up program; its use limited to that of identifying new primary lesions. It has been shown in a number of studies² that the chances of identifying a metachronous tumor are greatest in the first three years following definitive treatment of the primary tumor.

Therefore, based on currently available data, a reasonable follow-up program for patients after resection of a primary colorectal malignancy includes

1. History and physical examination performed every three months for three years, then every six months for two years, then annually.
2. CEA level determined every two months for three years, then every three months for two years, then annually.
3. Colonoscopy performed preoperatively or within one year of surgery, then annually for three years, then every three years.

The cost for this follow-up program would be \$2,683 over five years.

A positive study requires further action. If the CEA is positive, it should be repeated. A persistent elevation requires testing directed at common sites of recurrence. One should then obtain CT scans of the chest and abdomen/pelvis, liver function tests, a bone scintigram in the presence of bone pain, and colonoscopy. If all of these are negative, renal disease, breast malignancy, lung cancer, other gastrointestinal tumors, and hepatic dysfunction must be ruled out. At present, the only curative therapy for patients with recurrent disease is further surgery.¹

In the future, follow-up protocols may include the use of specific monoclonal antibodies (injected with a radionuclide and scanned) with intraoperative tumor localization and follow-up programs stratified by other variables (e.g., tumor ploidy, stage of the primary). It is hoped that with the development of new adjuvant treatments, the outlook for patients with recurrent disease will improve. Until then, we must be vigilant to identify disease in its earliest and, it is hoped, its most curable state.

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1. Sugarbaker PH, Gianola FJ, Dwyer A, Neuman NR. A simplified plan for follow-up of patients with colon and rectal cancer supported by prospective studies of laboratory and radiologic test results. *Surgery* 1987; 100:79-87.
2. Pommier R, Woltering E. Follow-up of patients after primary colorectal cancer resection. *Sem Surg Oncol* 1991; 7:129-32.

ALAN T. LEFOR, M.D.

Assistant Professor of Surgery and Oncology
University of Maryland School of Medicine

Tumor conferences are held weekly on Tuesday between 8 and 9 a.m. in Room NBW74 at the University of Maryland Medical System. Physicians are welcome to attend this open meeting and to present cases and pathology slides. Call 410-328-5224 by noon Monday to be placed on the schedule: Surgical Oncology Program, University of Maryland Medical System, Room N13E02, Baltimore, MD 21201.

Physician Placement Services

The Medical and Chirurgical Faculty of the State of Maryland maintains a Placement Service for the convenience of Maryland physicians, hospitals, and communities in search of candidates for positions available in our state. A detailed description of such opportunities should be forwarded to:

Physician Placement Service
1211 Cathedral St., Baltimore, MD 21201
(301-539-0872)

Physicians wishing to locate in Maryland are invited to submit a resume to be kept on file with the Physician Placement Service. Candidates are requested to inform the Faculty when they are no longer available for consideration for opportunities in Maryland.

MMJ announcements on the Classified Advertising page for Physician Placement Service are charged at the regular Classified Advertising rate.

Should children with diabetes go to camp?

Doctor, our Tommy is eight years old and has had diabetes for one year. At first he was very cooperative about following his meal plan and monitoring his blood glucose. Recently he has become stubborn about testing and he is begging food that he should not have from the neighbors. He wants to go away to camp this year, but since he can't get his diabetic management back on schedule even with our support and guidance, should we allow him to go away to camp?

Camps for diabetic children exist all over the United States for the problems that confront Tommy and his parents. About thirty years ago, Dr. Abraham Silver almost single-handedly began such a camp in Maryland—Camp Glyndon. It has become one of the finest camps of its kind in the country.

Camp Glyndon, which is accredited by the American Camping Association, is located in Glyndon, Maryland. Its primary purpose is to educate children with diabetes so they can have a thorough understanding of their problem while enjoying the fun and excitement of a normal camp setting.

It is recommended that all children having diabetes get the experience of living and playing with other children having a similar problem.

The camping session schedule for 1992 is as follows:

Session I	June 28-July 10	Ages 13-15
Session II	July 12-July 17	Family I
Session III	July 19-July 31	Ages 10-12
Session IV	August 2-August 7	Family II
Session V	August 9-August 14	Ages 10-12
Session VI	August 16-August 21	Ages 7-9

Attendance at other summer camps such as church-related camps, YMCA/YWCA camps, or scout camps may also be used as a camping experience if adequate health care support is available at those facilities. However, it would be desirable to have children with diabetes attend those camps *in addition* to Camp Glyndon or in alternate years with a diabetic camp.

For more information and an application for Camp Glyndon contact

American Diabetes Association, Maryland Affiliate
Camp Glyndon
2 Reservoir Circle, Suite 203
Baltimore, Maryland 21208
Telephone 410-486-5515

DeWITT E. DeLAWTER, M.D.
Editor

Auxiliary

Charles Ballard Senior Health Center

The Charles Ballard Senior Health Center is, to our knowledge, the first medical auxiliary project of its kind in Maryland—perhaps in the nation. The concept originated with the Auxiliary to the Anne Arundel Medical Society, which recognized that health education could have a positive impact on the utilization of health services and on community relations.

Health education not only provides information, offers guidance, and prevents health problems, but it can also enhance the physician/patient relationship. The Ballard Center offers physicians the opportunity to improve communication between the medical and senior citizen communities. Mutual respect and understanding are by-products of this communication. The senior participants become more aware of how to improve their mental and physical capabilities and are motivated to be active and enthusiastic partners in their health care.

The purpose of the center is to provide a broad program of primary health guidance in a recreational and social environment. The center also offers health education to the elderly and provides a link between the elderly and treatment recommended by the medical community.

History

- In November 1982, the Auxiliary to the Anne Arundel County Medical Society met with the director of the Office of Aging for the City of Annapolis regarding the possibility of opening a health center for the elderly in Anne Arundel County.
- In February 1983, a founding committee comprised of auxiliary members defined the center's purpose and outlined plans for implementation of a program. The center was named for a respected spokesman, Charles Ballard, who lobbied in the county and state legislature, and championed many problems faced by the senior community.
- After approval by the Anne Arundel County Medical Society in March 1983, the founding committee met with local hospital, city, and county representatives to assess available resources. An Advisory Board of

Community Representatives and a Board of Directors comprised of auxiliary members were formed.

- On April 21, 1983, the center opened to the public. Free programs were offered each Friday morning, September through June, for all seniors age fifty-five and over. A Charles Ballard Fund was established to support the center's operation; the retired Naval Academy chaplains contribute to this fund.

Today

The Charles Ballard Senior Health Center now has well over a hundred members. On Fridays, a speaker from the medical community presents topics on health care, prevention, and primary health guidance. The center also offers health screenings. These activities have resulted in a group of well-informed medical consumers. On Tuesdays and Fridays, there are aerobic exercise classes with Auxilian Sally Linhardt, and on Wednesdays, line dancing is led by Melvina Reese.

In October 1991, the Ballard Center members also acted as hostesses for the Annual Senior Health Fair held at the Annapolis Mall.

This past Christmas, there was a combined Christmas party with the children of the members of the Anne Arundel Medical Society and the members of the Charles Ballard Senior Health Center. The benefits were donated to Sarah's House, a facility for homeless families.

ELLENOR ALVAREZ

Director of the Charles Ballard Senior Health Center



Seniors participate in aerobics and line dancing.

Board of Physician Quality Assurance Actions

**In the matter of
Oscar J. Jackson
before the
Maryland Board of
Physician Quality Assurance
Order terminating probation**

By order dated November 1, 1983 (the 1983 order), the Commission on Medical Discipline (the commission), predecessor agency to the Board of Physician Quality Assurance (the board), found Oscar J. Jackson, M.D. (the respondent) guilty of committing prohibited acts as set forth in Health Occupations Article, *Annotated Code of Maryland* (HO) §14-504. Specifically, the commission found respondent guilty of being disciplined by a licensing or disciplinary authority, or convicted or disciplined by a court of any state or country, or disciplined by any branch or the United States uniformed services or the Veterans' Administration for an act that would be grounds for disciplinary action under this section. The commission revoked the respondent's license, stayed the revocation, and placed respondent on probation subject to conditions of the December 24, 1983 order of the California board. The order further provided that when the respondent could provide written evidence to the commission that respondent had completed all the probationary terms imposed by the California board, the commission would entertain a petition for termination of respondent's probationary status and reinstatement of his medical license. By letter dated December 30, 1988 and received by the board on January 4, 1989, the board reviewed respondent's petition for reinstatement. At its meeting on September 26, 1990, the board determined that respondent had fulfilled the conditions of probation contained in the 1983 order.

Finding of fact

Based on the information known and available to it, the board finds that

1. Respondent met all the conditions of the California board's order.

Conclusions of law

The board concludes, as a matter of law, that respondent has satisfactorily complied with all conditions of probation as set forth in the order of November 1, 1983.

Order

Upon the foregoing findings of fact and conclusions of law, it is this 26th day of September 1990 by a majority vote of the full authorized membership of the board

ORDERED, that effective as of the date of this order, the conditions of probation imposed upon respondent's practice of medicine by the board's 1983 order are hereby TERMINATED and of no further force and effect; and be it further

ORDERED, that respondent shall give the board written

notice of any intention to commence the active practice of medicine in the state of Maryland; and be it further

ORDERED, that this is a final order and as such is considered a public document pursuant to the Maryland Public Information Article, State Government Article, *Annotated Code of Maryland*, §§10-611 *et seq.*, specifically §10-617(h)(2)(vi).

ISRAEL H. WEINER MD, Chairperson
Maryland Board of Physician Quality Assurance

**In the matter of
Ernest A. Leipold, M.D.
before the
Maryland Board of
Physician Quality Assurance**

Surrender of license

Dear Dr. Weiner and members of the board:

Please be advised that I have decided to surrender my license to practice medicine in Maryland. I understand that I may apply for reinstatement of my license after I meet certain requirements which are described in this letter of surrender. Therefore, my decision to surrender my license is REVOCABLE.

I understand that this letter of surrender will be considered a PUBLIC document.

On July 24, 1991, the Board of Physician Quality Assurance (the board) voted to summarily suspend my medical license and charge me pursuant to *Md. Health Occ. Code Ann.* §14-404(a)(2), (8), (9), and (28) (1991 replacement volume). Sections 14-404(a)(2), (8), (9), and (28) provide in pertinent part

Subject to the hearing provisions of §14-405 of this subtitle, the board, on the affirmative vote of a majority of its full authorized membership, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:

- (2) Fraudulently or deceptively uses a license;
- (8) Is addicted to, or habitually abuses, any narcotic or controlled dangerous substance as defined in Article 27 of the *Code*;
- (9) Provides professional services
 - (i) While under the influence of alcohol; or
 - (ii) While using any narcotic or controlled dangerous substance, as defined in Article 27 of the *Code*, or other drug that is in excess of therapeutic amounts or without valid medical indication; and
- (28) Sells, prescribes, gives away, or administers drugs for illegal or illegitimate medical purposes.

The board also voted that if I surrendered my license it would not proceed to issue either the charges or the summary suspension. Prior to the issuance of charges against me, I advised my attorney, Thomas G. Ross, Esquire, and the board, that I wished to voluntarily surrender my license to the board. Consequently, my decision to surrender my license will result

Board of Physician Quality Assurance Actions

in the board's rescinding its vote to charge me and summarily suspend my license.

My decision to surrender my license and discontinue the practice of medicine has been prompted by my desire to avoid being charged under the Maryland Medical Practice Act, *Md. Health Occ. Code Ann.* §14-404 (1991 replacement volume). The basis of the summary suspension and charges against me is information obtained by the board regarding an investigation which led to my arrest on July 23, 1991. The board was provided information by the Maryland State Police, the Caroline County Drug Task Force, and the Drug Enforcement Administration concerning my alleged possession and distribution of controlled dangerous substances. The Maryland State Police charged me on July 23, 1991 in the District Court of Maryland for Queen Anne's County in *State of Maryland v Ernest A. Leipold* tracking number 001400M0. In the above captioned case, I am charged with six counts of distribution of a controlled dangerous substance, six counts of possession of a controlled dangerous substance and two counts of possession of drug paraphernalia. I understand that the information obtained in the criminal investigation of me is the basis of the summary suspension and charges voted against me by the board pursuant to the Maryland Medical Practice Act.

I understand that this letter of surrender shall become a public document and shall become effective immediately upon its acceptance by the board, that date being the date on which the board approves this letter of surrender.

I further understand that the surrender of my license to practice medicine in the state of Maryland shall stay in effect pending the resolution of all criminal charges against me in the state of Maryland. In the event that the criminal charges against me in the District Court of Maryland for Queen Anne's County are dismissed, this surrender will remain in effect until the case is considered by the Grand Jury for Queen Anne's County, Maryland. If I am indicted, or charged by criminal information in the Circuit Court for Queen Anne's County, this surrender will remain in effect until the resolution of that indictment or criminal information.

After the resolution of all charges stemming from the criminal investigation which resulted in my arrest on July 23, 1991, I may petition the board for reinstatement of my license to practice medicine in the state of Maryland. I understand that the board may take into account the actions of the Maryland criminal courts in making a determination of whether to reinstate my license to practice medicine in the state of Maryland.

I have not practiced medicine in Maryland since July 24, 1991. I hereby affirm that I do not have any hospital privileges in Maryland, or any other state in the United States. I am not licensed to practice medicine in any other state of the United States of America or any other country.

I agree to sign DEA Form 104, Voluntary Surrender of Controlled Substances Privileges. I acknowledge that the board will send my DEA registration certificate, DEA form

104, and a copy of this letter of surrender to Robert Bickel, group supervisor, DEA, 31 Hopkins Plaza, Room 955, Baltimore, Maryland 21201.

I hereby affirm that I do not have any DEA order forms for schedule I or II drugs.

I acknowledge that the board will send my Maryland CDS registration certificate and a copy of this letter of surrender to Charles Tregoe, chief, Division of Drug Control, 4201 Patterson Avenue, Baltimore, Maryland 21215.

Before the board accepts this letter of surrender as a resolution of case number 92-0009, I must present to the board the following:

1. Maryland license D06685, renewal certificate, and wallet-size renewal card.
2. United States Drug Enforcement Administration Registration Certificate AL9355757, which permits me to prescribe controlled dangerous substances in Maryland, and DEA form 104.
3. Maryland Controlled Dangerous Substances Registration Certificate #M17425 issued by the Maryland Division of Drug Control.
4. All prescription pads in my possession or control.
5. All controlled substances in my possession or control other than those that are prescribed to me by another licensed physician.

In executing this letter of surrender, I understand that I may apply for reinstatement of my license to practice medicine in Maryland upon the final resolution of the case known as *State of Maryland v Ernest A. Leipold* presently before the District Court of Maryland for Queen Anne's County. If I apply for reinstatement of my license I acknowledge that I bear the burden of demonstrating to the board that I am competent to practice medicine. I understand that the board will require a statement from my treating physician which states that he or she believes I am competent to practice medicine. I further understand that the board may require an independent psychiatric evaluation of me prior to deciding whether to reinstate my license. I understand that the board may consider the independent psychiatric evaluation of me in deciding whether to reinstate my medical license.

Further, I understand that I must demonstrate that I have the cognitive and clinical competence to practice medicine. Additionally, I must demonstrate that I have taken fifty continuing medical education hours applicable to the field of medicine I wish to enter, for each year I have not practiced. I further understand that the board may require that I be appropriately evaluated for clinical competence prior to my reinstatement. I understand that I must demonstrate to the board's satisfaction that I possess good moral character as specified in *Md. Health Occ. Code Ann.* §14-307(b) (1991 replacement volume).

Until the board grants my request for reinstatement, I understand that I may not give medical advice to any individual, for compensation or otherwise, and cannot prescribe

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medication. In other words, I understand that the surrender of my license means that I am an unlicensed physician.

Finally, I wish to make clear that I have consulted with an attorney before signing this REVOCABLE letter of surrender of my license to practice medicine in the state of Maryland. I understand the nature of the board's actions and this letter of surrender fully. I make this decision knowingly and voluntarily. My action, by virtue of this letter, is not intended to be, nor should it be construed as, an admission of any guilt on my part to any allegations of wrongdoing made in the criminal charges against me or contemplated by the Board of Physician Quality Assurance.

ERNEST A. LEIPOLD, M.D.

On behalf of the Board of Physician Quality Assurance, on this 13th day of August, I accept Ernest A. Leipold, M.D.'s PUBLIC REVOCABLE surrender of his license to practice medicine in Maryland.

ISRAEL H. WEINER MD, Chairperson
Maryland Board of Physician Quality Assurance

■ ■ ■
In the matter of
Bautista Perez-Sanz, M.D.
before the
Maryland Board of
Physician Quality Assurance
Final order

Based on information received by the Board of Physician Quality Assurance of the state of Maryland (the board), the board charged Bautista Perez-Sanz (respondent) on June 11, 1991 under the Maryland Medical Practice Act (the act), *Md. Health Occ. Code Ann. Section 14-401 et seq.*

The pertinent provisions of the act are as follows:

Section 14-404. Denials, reprimands, probations, suspension, and revocations—Grounds.

(a) In general. Subject to the hearing provisions of section 14-405 of this subtitle, the board, on the affirmative vote of a majority of its full authorized membership, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:

(21) Is disciplined by a licensing or disciplinary authority or convicted or disciplined by a court of any state or country or disciplined by any branch of the United States uniformed services or the Veterans' Administration for an act that would be grounds for disciplinary action under this section;

The grounds underlying the charges of this section are that respondent

(3) Is guilty of immoral or unprofessional conduct in the practice of medicine.

(22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality

medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this state.

The board notified respondent that if respondent did not request a hearing, the board would issue this final order.

Based on clear and convincing evidence, the board, on the affirmative vote of a majority of its full authorized membership considering this case, issues this final order.

Findings of fact

A. The board finds as follows:

1. At all times relevant to these charges, the respondent was and is licensed to practice medicine in the state of Maryland;
2. The respondent was notified by the board on June 4, 1991 of charges filed against him and that the board could sanction respondent as a result of these charges;
3. The respondent was informed that this final order would be executed thirty days from the respondent's receipt of the board's notification, unless respondent requested a hearing;
4. Respondent received the board's charges and notice of intent to sanction under the Maryland Practice Act on June 24, 1991.
5. Respondent had to request a hearing by July 24, 1991, in order for the board not to execute this Final Order;
6. Respondent did not request a hearing by July 24, 1991.

B. The board further finds that

1. Appropriate peer review includes the review of a physician's practice by a licensing or disciplinary authority of another jurisdiction.
2. On October 13, 1989, respondent entered into a consent order (the order) with the Department of Health of the State Board of Professional Medical Conduct of the State of New York, Exhibit 1, in which respondent admitted guilt to failing to maintain adequate medical records and ordering excessive treatment;
3. In his consent order of October 13, 1989, respondent agreed that his

License to practice as a physician in the state of New York be suspended for a period of two years, that execution of the last one year, ten months, and fifteen days be stayed, at which time I [respondent] be placed on probation for one year, ten months, and fifteen days under the terms set forth in the exhibit marked as Exhibit B;

4. Failing to maintain adequate records is a failure to meet appropriate standards of care;
5. Failing to maintain adequate records is unprofessional conduct in the practice of medicine.
6. Ordering excessive treatment is a failure to meet appropriate standards of care;
7. Ordering excessive treatment is unprofessional conduct in the practice of medicine.

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8. Suspension of respondent's license and being placed on probation by the Department of Health of the State Board of Professional Medical Conduct of the State of New York is being disciplined by a licensing or disciplinary authority.

Conclusions of law

Respondent committed the following prohibited acts:

1. Respondent was disciplined by a licensing or disciplinary authority or convicted or disciplined by a court of any state or country or disciplined by any branch of the United States uniformed services or the Veterans' Administration for an act that would be grounds for disciplinary action under this section [*Md. Health Occ. Code Ann.* Section 14-404 (a) (21)]
2. The underlying grounds for this disciplinary action were respondent's failure to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this state [*Md. Health Occ. Code Ann.* Section 14-404 (a) (22)], and that respondent was guilty of immoral or unprofessional conduct in the practice of medicine [*Md. Health Occ. Code Ann.* Section 14-404 (a) (3)].

Order

It is this 13th day of August 1991, by an affirmative vote of a majority of the full authorized membership of those members of the board who considered this case,

ORDERED, that respondent's license to practice medicine in the state of Maryland (the state) is **SUSPENDED**. Said suspension is **STAYED** provided that respondent complies with the following conditions of probation:

1. Respondent must comply with all conditions of his probation with the state of New York as set forth in Exhibit 1; and
2. Respondent shall not practice medicine in the state of Maryland until respondent appears before a settlement conference of the board and obtains the approval of the board;

and be it further

ORDERED, that upon satisfactory completion of the requirements of the terms of his probation with the state of Maryland, respondent may petition the board for reinstatement of his license in Maryland without any conditions; and be it further

ORDERED, that the stay of respondent's suspension shall be lifted if respondent fails to comply with any of the terms of this final order; and be it further

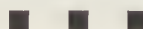
ORDERED, that this is a final order and as such will be considered a public document pursuant to *Md. State Gov't Code Ann.* Section 10-611 *et seq* (1989 Cum. Supp.).

ISRAEL H. WEINER MD, Chairperson
Maryland Board of Physician Quality Assurance

Notice of right to appeal

Pursuant to *Md. Health Occ. Code Ann.* Section 14-408 (b) (1991) there is a right to take a direct judicial appeal. Any appeal shall be made as provided for in judicial review of a final decision in the Administrative Procedure Act, State Government Article, and the B Rules of Maryland Procedure, 1991.

ISRAEL H. WEINER MD, Chairperson
Maryland Board of Physician Quality Assurance



In the matter of
Cleveland Williams, M.D.
before the
Maryland Board of
Physician Quality Assurance

Surrender of License

Dear Dr. Weiner and members of the board:

Please be advised that I have decided to surrender my license to practice medicine in the state of Maryland. I understand that I may not give medical advice or treatment to any individual, with or without compensation, cannot prescribe medications, or otherwise engage in the practice of medicine as it is defined in *Md. Health Occ. Code Ann.* §14-101 (1991 replacement volume). In other words, I understand that surrender of my license means that I am in the same position as an unlicensed individual. This decision to surrender my license to practice medicine in the state of Maryland is **REVOCABLE** and public.

This letter of surrender shall become a public document and shall become effective immediately upon its acceptance by the Board of Physician Quality Assurance (the board), that date being the date on which the board accepts this letter of surrender.

My decision to surrender my license to practice medicine in Maryland has been prompted by an investigation of my practice, which was undertaken in accordance with the consent order reached between myself and the Commission on Medical Discipline, dated June 21, 1988. This investigation included a review of my practice conducted by the Peer Review Committee of the Medical and Chirurgical Faculty of the State of Maryland. The board's investigation resulted in charges under the Maryland Medical Practice Act (the act). Specifically, the board charged me with the commission of prohibited acts under *Md. Health Occ. Code Ann.* §14-404(a)(22) (1991 replacement volume). Section 14-404(a)(22) provides in pertinent part:

Subject to the hearing provisions of §14-405 of this subtitle, the board, on the affirmative vote of a majority of its full authorized membership, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:

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- (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this state.

I received a copy of the statement of charges under the Maryland Medical Practice Act as described above, on July 17, 1991. A copy of the statement of charges is included as Appendix A.

I have decided to surrender my license and to discontinue the practice of medicine in Maryland to avoid further prosecution on the aforementioned charges under the Maryland Medical Practice Act. The basis for the charges against me would include the findings of the investigation as described above.

I affirm that I have an office-based practice, located at Suite 103, 1111 Spring Street, Silver Spring, Maryland 20910. I affirm that I will terminate this and any other practice that I have in Maryland upon the acceptance of this letter of surrender by the board. I acknowledge that I have no hospital privileges in Maryland.

I understand that the board will advise the Federation of State Medical Boards and the National Practitioners' Data Bank, as required by Senate bill 99-660, through this letter of surrender, and any response to inquiry, that I have surrendered my license to practice medicine as resolution of the matters pending against me. I also understand that, in the event that I would apply for reinstatement of my license in Maryland, or apply for licensure in any other state or jurisdiction, that this letter of surrender, and all underlying documents, may be released or published by the board to the same extent as a final order which would result from a disciplinary action, under the Public Information Act, State Gov't. Code Ann. §§10-611 *et seq.*

I affirm that I have a current Maryland Controlled Dangerous Substances Registration Certificate M15956, expiration date June 30, 1992, issued by the Maryland Division of Drug Control; and that I have a current United States Drug Enforcement Administration (DEA) Certificate for the State of Maryland. Certificate AW1280332, expiration date May 31, 1992, issued by the DEA.

I acknowledge that, on the date the board accepts this letter of surrender, I must present to the board Maryland License D26740, including any renewal certificates and wallet-sized renewal cards; and Maryland Controlled Dangerous Substances Registration Certificate M15956, including any prescription pads bearing my name and any prescription ordering forms in my possession or under my control.

I agree to sign DEA form 104, voluntary surrender of controlled dangerous substances privileges. I acknowledge that the board will send my DEA registration certificate, DEA form 104, and a copy of this letter of surrender to Kathryn P. Daniels, diversion group supervisor, DEA, 400 6th Street, S.W., Washington, DC 20024.

I acknowledge that the board will send my Maryland Controlled Dangerous Substances Registration Certificate

and a copy of this letter of surrender to Charles H. Tregoe, chief, Division of Drug Control, 4201 Patterson Avenue, Baltimore, Maryland 21215.

I affirm that I have a medical license in the District of Columbia. I acknowledge that, on the date the board accepts this letter of surrender, the board will send a copy of this document to John P. Hopkins, executive director of the District of Columbia Board of Medicine, 605 G Street, N.W., Room 202, Lower Level, Washington, DC 20001.

Finally, I wish to make clear that I have consulted with an attorney before signing this letter SURRENDERING my license to practice medicine in the state of Maryland. I understand both the nature of the board's actions and this letter of surrender fully. I make this decision knowingly and voluntarily.

CLEVELAND WILLIAMS, M.D.

Appendix A

In the matter of
Cleveland Williams, M.D.
before the
Maryland Board of
Physician Quality Assurance

Charges under the Maryland Medical Practice Act

Based on information received by the State Board of Physician Quality Assurance (the board), the board hereby charges Cleveland Williams, M.D. (the respondent) under the Maryland Medical Practice Act (the Act), *Md. Health Occ. Code Ann.* (HO) §14-404(a)(22) (1991 Rep. vol.).

The pertinent provision of the act under HO §14-404 provides the following

- (a) Subject to the hearing provisions of §14-405 of this subtitle, the board, on the affirmative vote of a majority of its full authorized membership, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee

- (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this state. [See H.O. §14-404(a)(22).]

Allegations of fact

The board bases its charges on the following facts that the board has cause to believe are true:

1. On or about August 3, 1981, the Board of Medical Examiners of the state of Maryland granted respondent a license to practice medicine.
2. On or about March 23, 1988, the Commission on Medical Discipline (CMD) issued a charge letter charging the respondent with violating HO §14-504(3) of the act ("is guilty of immoral conduct in the practice of medicine ..."), in which it was alleged that the respondent misrepresented his qualifications in regard to board certification in obstetrics and gynecology in applying for hospital staff privileges at Washington Adventist Hospital (WAH) and in applying for membership in the patient referral service of the Montgomery County Medical Society (MCMS).

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3. On or about June 21, 1988, the respondent entered into a consent order with the CMD whereby the CMD withdrew the charge of H.O. §14-504(3) and substituted a charge under §14-504(4), in which it was alleged that the respondent "is professionally, physically, or mentally incompetent." The respondent then admitted that he had violated HO §14-504(4) of the act, in misrepresenting his qualifications in applying for hospital staff privileges at WAH and in forms submitted to the MCMS.
4. As a result of the consent order reached between the respondent and the CMD (as described in paragraph three above), the respondent's license to practice medicine in the state of Maryland was suspended for a period of three years and ninety days; after the first ninety days of the suspension occurred, the suspension was stayed. The respondent was then placed on probation for a period of three years, subject to certain conditions, among which were continued psychiatric treatment, notification of the CMD of any changes in the nature of the respondent's office practice, and periodic peer reviews as necessary.
5. The Peer Review Management Committee of the Medical and Chirurgical Faculty of the State of Maryland (Med Chi) requested that the Peer Review Committee (the PRC) of Med Chi conduct a peer review of the respondent's practice. The PRC of Med Chi referred the matter to Lois E. Wehren, M.D., board certified in obstetrics and gynecology, for peer review.
6. The respondent failed to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care in several areas described in more detail in the individual patient summaries, *infra*. The respondent's medical record charts show a consistent pattern of inadequate documentation, particularly as the records relate to the patient's history and physical examinations. The patient's history often lacks such vital information as the patient's present illness(es), past medical and surgical history, family and social history, and menstrual history. The medical records often do not indicate that breast or pelvic examinations were performed. In those instances where documentation of examinations does exist, the findings of those examinations are not sufficiently detailed. Appropriate laboratory tests are not reliably ordered, nor are abnormal values determined by those tests appropriately treated. The medical records further indicate that the respondent neglected to treat potentially dangerous conditions in his patients, and failed to adequately formulate and document treatment plans in the conditions so diagnosed.

The following deficiencies were found in regard to the following patients:

Patient A

Patient A, a 32-year-old female, sought obstetric care from the respondent on one occasion, April 11, 1990. The patient's last menstrual period (LMP) was October 27, 1989. The patient's estimated date of confinement (EDC) was calculated as July 25, 1990.

The respondent failed to meet the appropriate standard of care in regard to this patient for the following reasons:

1. The respondent did not document an adequate history of the patient in the patient's medical record. The appropriate standard of medical care requires that the obstetrician-gynecologist (OB/GYN) document an adequate history of the patient in the medical record, which should include, but not be limited to, a

history of present illnesses, past medical history, and family and social history. The medical record fails to contain documentation of these aspects of the patient's history.

2. The respondent failed to provide adequate prenatal care to the patient in that the respondent did not order appropriate diagnostic tests and examinations in assessing the patient. In the delivery of prenatal care, the appropriate standard of medical care requires that the OB/GYN order certain routine laboratory tests, including, but not limited to, a serologic test for syphilis (STS), gonorrhea (GC), Rubella titer, chlamydia, repeat complete blood count (CBC), and a 50 gm glucose screening test. There is no evidence in the medical record that the respondent ordered these tests. The patient had been seen in the emergency room of Holy Cross Hospital on March 5, 1990, at which point a urinalysis, CBC, and human chorionic gonadotropin (HCG) tests were performed. The CBC showed a hemoglobin (HGB) of 9.5 gm, a value consistent with anemia. The respondent did not order any further laboratory tests after these tests were taken.

There is no evidence in the medical record that the respondent performed a general physical examination or a pelvic examination of the patient at the patient's initial visit. The appropriate standard of care requires that the OB/GYN perform an adequate physical examination of the patient at or near the patient's initial prenatal visit.

3. The respondent failed to address the patient's prenatal anemia. On March 5, 1990, laboratory tests performed at Holy Cross Hospital, found in the medical record chart, indicated that the patient was anemic (hematocrit (HCT) 29.0 percent, HGB 9.5 gm.). Under the above circumstances, the appropriate standard of medical care requires that at a minimum, the OB/GYN prescribe vitamins and iron supplements to address the patient's condition and periodically re-evaluate the patient's blood count. There is no evidence in the medical record that the respondent ordered these tests or attempted to treat the patient's condition.

Patient B

Patient B, a 24-year-old female, sought obstetric care from the respondent from July 1989 through March 1990. The patient's LMP was June 19, 1989. The patient's initial prenatal visit with the respondent was on July 31, 1989. The patient gave birth to a live infant on March 19, 1990. The patient saw the respondent on two postpartum visits in April and May 1990.

The respondent failed to meet the appropriate standard of care in regard to this patient for the following reasons:

1. The respondent did not document in the patient's medical record an adequate history during the patient's initial visit. The appropriate standard of medical care requires that the OB/GYN document an adequate history of the patient, which should include, but not be limited to, the patient's past medical history, family history, and hospitalizations. There is no indication in the medical record that the respondent recorded this information.
2. The respondent failed to perform, or did not document that he had performed, a complete physical examination of the patient during the patient's initial visit. The appropriate standard of medical care requires that the OB/GYN perform an adequate physical examination of the patient during the patient's initial visit. There is no indication in the record that the respondent performed examination of pulmonary, respiratory, or cardiac systems, or a complete abdominal examination.

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The respondent did not order certain prenatal diagnostic tests. There is no indication in the medical record that the respondent ordered tests for GC, chlamydia, hepatitis B surface antigen (HBsAg), and did not order a 50 gm glucose screen (at twenty-eight weeks). Although the respondent ordered a CBC during the patient's initial visit, there is no indication in the record that the respondent ordered a follow-up CBC thereafter during the patient's prenatal care. The appropriate standard of medical care requires that the OB/GYN order these tests in the delivery of prenatal care to a patient.

3. The respondent failed to address the patient's borderline anemia. The patient's initial CBC, taken August 1, 1989, indicated that the patient was borderline anemic (HCT 31.5 percent, HGB 10.6 gm). There is no indication in the medical record that the respondent prescribed an iron supplement or prenatal vitamins, or addressed the patient's condition during the patient's prenatal care.

Patient C

Patient C, a 34-year-old female, received prenatal care from the respondent on two occasions, November 29, 1989 and May 30, 1990; and saw the respondent for a postpartum visit on June 20, 1990. The patient's LMP was September 13, 1989. The patient delivered a live infant on June 1, 1990. The respondent also performed a postpartum left partial salpingectomy on the patient on June 1, 1990.

The respondent failed to meet the appropriate standard of care in regard to this patient for the following reasons:

1. The medical record is inadequate. The record for this patient's prenatal course consists of two brief entries. The appropriate standard of medical care requires that the OB/GYN document, among other pertinent data, the patient's past medical history, previous surgeries, and prior pregnancies. There is no documentation in the respondent's records of these aspects of the patient's history. Although the patient had previously undergone a right salpingectomy, this fact is not listed in the patient history (reference to this surgical procedure is noted in an operative note for the postpartum left partial salpingectomy described above).

In another example, an insurance certification notice dated June 7, 1990 and contained in the medical record, indicates that the patient was hospitalized on June 5, 1990 for a pulmonary embolism. No reference to this fact exists in the respondent's June 20, 1990 postpartum visit entry.

The respondent did not adequately document or describe his evaluation of the patient's chief complaint in the November 29, 1989 prenatal visit. The appropriate standard of medical care requires that the OB/GYN adequately document the patient's chief complaint in the patient record. In this entry, the respondent noted that the patient had "c/o pain on right side, epigastric, lower quad." No assessment of this pelvic pain is provided in the medical record.

2. The respondent failed to perform, or failed to document that he had performed, a physical examination on the patient's November 29, 1989 prenatal visit. The appropriate standard of medical care requires that the OB/GYN perform a general physical examination of the patient at or near the patient's initial visit, and document these findings in the medical record. Although the respondent conducted breast and pelvic examinations of the patient, the respondent did not perform, or did not document the findings of, the general physical examination of the patient.

Patient D

Patient D, a 23-year-old female, sought gynecologic care from the respondent on one occasion, June 13, 1990, for vulvar bumps. The respondent diagnosed the patient as having folliculitis vulvae, and ordered a follow-up visit in six months.

The respondent failed to meet the appropriate standard of care in regard to this patient for the following reasons:

1. The respondent's medical history is inadequate. The appropriate standard of medical care requires that the OB/GYN document a complete history of the patient in the record, which should include, but not be limited to, the patient's past medical history, drug sensitivities, prior pregnancies, and social and family history. There is no indication in the medical record that the respondent obtained this information.
2. The respondent failed to perform, or failed to document that he had performed, a physical examination of the patient on the patient's June 13, 1990 office visit. The appropriate standard of medical care requires that the OB/GYN perform a general physical examination of the patient (particularly when that individual is a first-time patient) and to document the findings of the physical examination in the medical record.
3. The respondent did not appropriately treat the patient's diagnosed condition. Under the above circumstances, the appropriate standard of medical care requires that the OB/GYN formulate a treatment plan to treat the patient's condition, which would include, but not be limited to appropriate medication and, perhaps, vulvar biopsy. There is no indication in the medical record that the respondent undertook any kind of treatment of the patient's condition.

Patient E

Patient E, a 25-year-old female, sought prenatal care from the respondent on one occasion, April 4, 1990. The patient's LMP was January 13, 1990. The patient's EDC was October 21, 1990.

The respondent failed to meet the appropriate standard of care in regard to this patient by failing to document an adequate history of the patient in the patient's medical record. The appropriate standard of medical care requires that the OB/GYN document an adequate history of the patient, which should include, but not be limited to, documentation of the patient's past medical history, family history, hospitalization, and operations. The medical record fails to contain documentation of these aspects of the patient's history.

Patient F

Patient F, a 30-year-old female, sought obstetric and gynecologic care from the respondent from 1985 through 1990. During this time period, the patient received prenatal care for the period June 1988 through February 1989. The patient's LMP was April 25, 1988. The patient delivered a live female child on February 6, 1989.

The respondent failed to meet the appropriate standard of care in regard to this patient by failing to provide adequate prenatal care, in that he did not order certain laboratory tests to monitor the patient's condition. Although the respondent ordered a CBC at or near the patient's initial prenatal visit, the respondent did not order a subsequent CBC until thirty-weeks gestation. In addition, the respondent did not order a 50 gm glucose screening test at twenty-eight weeks gestation. The patient gained 46 pounds during her pregnancy.

Under the above circumstances, the appropriate standard of medical care requires that the OB/GYN perform a repeat CBC on a

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pregnant patient at twenty-eight weeks gestation to monitor the patient for such conditions as anemia or, more commonly, thrombocytopenia. Furthermore, the appropriate standard of medical care requires that the OB/GYN order a 50 gm glucose screening at twenty-eight weeks gestation to evaluate the patient for gestational diabetes. There is no indication in the medical record that the respondent ordered these tests in a timely fashion. This failure to order the glucose screening test was particularly significant in view of the patient's weight gain, which was suggestive of possible glucose intolerance.

Patient G

Patient G, a 28-year-old female, initially sought prenatal care from the respondent on December 6, 1989. The patient's LMP was October 3, 1989. During the patient's pregnancy, the patient gained a total of approximately three pounds.

The respondent failed to meet the appropriate standard of care in regard to this patient for the following reasons:

1. The respondent did not document an adequate history of the patient in the patient's medical record. The appropriate standard of medical care requires that the OB/GYN document an adequate history of the patient in the patient's medical record, which should include, but not be limited to, a history of present illnesses, past medical history, menstrual history, and family and social history. The medical record fails to contain documentation of these aspects of the patient's history.
2. The respondent did not monitor the patient's pregnancy appropriately, particularly in view of the patient's abnormal weight gain. The appropriate standard of medical care requires that the OB/GYN monitor a patient's weight gain during the course of the patient's pregnancy. When the patient's weight gain is abnormally low, as in this patient, the appropriate standard of medical care requires that the OB/GYN evaluate the patient's poor weight gain by means of periodic sonograms, and possibly nonstress testing. Although the respondent ordered a sonogram at twenty-one weeks, he did not order any ultrasounds thereafter during the patient's prenatal care. Furthermore, the respondent did not order a CBC or a 50 gm glucose screening test at twenty-eight weeks gestation. The appropriate standard of medical care requires that the OB/GYN order these tests at this point in the patient's pregnancy in the assessment of the patient's pregnancy. There is no indication in the medical record that these tests were ordered by the respondent.

Patient H

Patient H, a 36-year-old female, sought gynecologic care from the respondent on one occasion, June 27, 1990.

The respondent failed to meet the appropriate standard of care in regard to this patient for the following reasons:

1. The respondent did not document the chief complaint or an adequate history of the patient. Based on the fertility tests ordered by the respondent, it appears that the patient's complaint related to infertility. The appropriate standard of medical care requires that the OB/GYN document an adequate history of the patient in the medical record, which should include, but not be limited to, documentation of the patient's past medical history, family history, hospitalizations, operations, menstrual history, and, in this case, a complete fertility history.

2. The respondent failed to document the results of a general physical examination. The appropriate standard of medical care requires that the OB/GYN document the results of a physical examination of the patient, particularly under the above circumstances, where the patient is receiving care for the first time from the respondent and, presumably, is seeking medical care for possible infertility.

Patient I

Patient I, a 19-year-old female, sought gynecologic care from the respondent on one occasion, April 4, 1990. The patient visited the respondent for a prescription for oral contraceptives.

The respondent failed to meet the appropriate standard of care in regard to this patient for the following reasons:

1. The respondent did not document an adequate history of the patient in the patient's medical record. The appropriate standard of medical care requires that the OB/GYN document an adequate history of the patient, which should include, but not be limited to, the patient's past medical history and family history. These aspects of the patient's history are not documented in this record.
2. The respondent failed to perform a physical examination of the patient prior to prescribing oral contraceptives. The appropriate standard of medical care requires that the OB/GYN perform a complete physical examination of the patient at the patient's initial visit. There is no indication in the medical record that the respondent performed an examination of the patient prior to prescribing oral contraceptives.

Patient J

Patient J, a 29-year-old female, received prenatal obstetric care from the respondent in February and March 1990. The respondent assumed the care of the patient during her eighth month of pregnancy. A CBC, taken February 23, 1990, indicated that the patient was anemic (HCT 32.0 percent, HGB 10.4 gm.). On March 21, 1990, the respondent scheduled the patient for a cesarean section and tubal ligation, which were performed on March 23, 1990. The patient delivered a live male on that date.

The respondent failed to meet the appropriate standard of care in regard to this patient by failing to appropriately manage the patient's anemia. The medical record chart contains a CBC laboratory report from February 24, 1990, indicating that the patient was anemic. In his progress notes, on March 14, 1990, the respondent noted that the patient's hemoglobin reading was 10.4 gm. The appropriate standard of medical care requires that the OB/GYN prescribe prenatal vitamins and iron supplements and perform follow-up blood work under these circumstances. This is particularly significant in view of the patient's scheduled surgery.

Patient K

Patient K, a 16-year-old female, sought gynecologic care from the respondent on one occasion, April 25, 1990. The patient's LMP was March 18, 1990. The patient's medical record chart, at one point, indicates that the patient "did EPT." At another point in the chart, in the physical examination section, the respondent notes "may be pregnant."

The respondent failed to meet the appropriate standard of care in regard to this patient for the following reasons:

1. The respondent failed to keep an adequate medical record in regard to this patient. The appropriate standard of medical care

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requires that the OB-GYN document an adequate history of the patient, which should include, but not be limited to, documentation of the patient's past medical history, hospitalizations, and family history. There is no indication in the medical record that these aspects of the patient's history were documented.

2. The respondent also failed to document that he had performed a general physical examination and a breast examination. The appropriate standard of medical care requires that the OB/GYN document the results of a physical examination and breast examination in the medical record chart if these examinations were performed. There is no documentation in the patient's medical record that the respondent performed these examinations.
3. The respondent did not appropriately manage this patient's condition. The medical record indicates that the patient may have been pregnant. The respondent ordered a pregnancy test, but also concomitantly prescribed Triphasil, an oral contraceptive, for the patient. The appropriate standard of medical care requires that the OB/GYN make a determination as to whether the patient is pregnant prior to prescribing oral contraceptives. The prescribing of oral contraceptives to women who are pregnant or are possibly pregnant is contraindicated in that oral contraceptives may have adverse effects on the pregnancy. There is no indication in the medical record that the respondent advised the patient to wait for the results of the pregnancy test or the onset of menses prior to using the oral contraceptives prescribed.

Patient L

Patient L, a 33-year-old female, sought gynecologic and obstetric care from the respondent from 1988 through 1990. During this time period, the patient tested positive for pregnancy in July 1988, and had a therapeutic abortion on August 6, 1988. The patient was diagnosed thereafter on August 18, 1988 as being hypertensive (blood pressure (BP) 154/94). The patient again tested positive for pregnancy on November 17, 1989. During the course of the prenatal care, the respondent diagnosed the patient as being hypertensive. The patient delivered a live infant by cesarean section on April 29, 1990.

The respondent failed to meet the appropriate standard of care in regard to this patient by failing to appropriately manage the patient's hypertensive condition. During the course of the patient's prenatal care, the respondent noted the patient's BP at 140/100 at twenty-four-weeks gestation (March 21, 1990). The respondent prescribed Aldomet 250 mg, an antihypertensive medication, but did not order any further diagnostic tests or consultation for assessment of this condition. The respondent did not see the patient for another two weeks, until April 4, 1990, when the patient's BP was 150/100. The respondent increased the dosage of Aldomet. On April 11, 1990, the respondent noted the patient's BP at 170/90. The patient was admitted to Washington Hospital Center on April 17, 1990 with a BP of 160/109. The patient's BP on the date of discharge, April 19, 1990, was 156/106. The consultant's report, dated April 19, 1990, indicated that the patient had complained of severe headaches for two weeks. Under the above circumstances, the appropriate standard of medical care requires that the OB/GYN undertake more aggressive measures to control the patient's hypertension, including additional medication and earlier consultation and hospitalization. As a result of the patient's hypertension, the patient delivered a premature infant by cesarean section at twenty-nine-weeks gestation. In this case, the respondent followed the patient's hypertensive condition for one

month before more aggressive action (i.e., hospitalization, additional medications) was undertaken.

Patient M

Patient M, a 22-year-old female, sought gynecologic care from the respondent on one occasion, April 18, 1990. The patient had had an abnormal (Class II) Pap smear in February 1990.

The respondent failed to meet the appropriate standard of care in regard to this patient for the following reasons:

1. The respondent did not document an adequate history of the patient in the patient's medical record. The appropriate standard of medical care requires that the OB/GYN document an adequate history of the patient in the patient's medical record, which should include, but not be limited to, the patient's past medical, family, and social history. The medical record fails to contain documentation of these aspects of the patient's history.
2. In the assessment of the patient's condition, the appropriate standard of care requires that the OB/GYN perform a general physical examination. Although the medical record indicates that the respondent performed pelvic and breast examinations, there is no indication in the record that the respondent performed a general physical examination of this new patient.
3. The respondent did not adequately evaluate the patient's condition. The appropriate standard of medical care requires that the OB/GYN order follow-up tests to evaluate the earlier abnormal Pap smear. These tests would include, but would not be limited to, a second Pap smear and colposcopy with directed biopsies. The appropriate standard of medical care would also include formulation and documentation of an adequate treatment plan in the medical record. There is no indication in the patient's medical record that the respondent ordered any of the above tests, or that the respondent formulated a proposed treatment plan or requested follow-up visits to monitor the patient's condition.

Patient N

Patient N, a 16-year-old female, sought gynecologic care from the respondent on one occasion, May 23, 1990. At this visit, the respondent prescribed oral contraceptives and advised the patient to return for follow-up care in six months.

The respondent failed to meet the appropriate standard of care in regard to this patient for the following reasons:

1. The respondent failed to document an adequate medical record in regard to this patient. The appropriate standard of medical care requires that the OB/GYN, among other data, document the patient's chief and secondary complaints; history of present illness; past medical history; hospitalizations; family and social history. The medical record fails to contain documentation of this data.
2. The respondent did not appropriately assess this patient prior to prescribing oral contraceptives. Under those circumstances where an OB/GYN provides care to a new patient and, during that initial visit prescribes oral contraceptives, the appropriate standard of medical care requires that the OB/GYN perform a physical examination of the patient, including a review of respiratory, pulmonary, and cardiac systems, as well as breast and pelvic examinations. Prior to the prescribing of oral contraceptives, the appropriate standard of medical care requires that the patient's BP be evaluated to ensure that the BP is not elevated. The use of oral contraceptives may be contraindicated in those

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patients with elevated blood pressure. There is no indication that the respondent performed a general physical examination of the patient, and no indication in the medical record that the respondent documented the patient's BP, if indeed the respondent checked the patient's BP.

Patient O

Patient O, a 33-year-old female, sought obstetric and gynecologic care from the respondent at various times from 1981 through 1990. During the relevant treatment period in 1988, the patient saw the respondent on two occasions, August 18 and September 15. The patient's LMP relative to those visits was May 25, 1988. The patient initially presented with amenorrhea. The respondent prescribed Provera, a synthetic progestational agent. At the September 15, 1988 visit, the patient complained of sharp, intermittent left-sided pelvic pain. The respondent ordered an ultrasound, and prescribed oral contraceptives. In neither visit did the respondent order any tests to confirm or rule out pregnancy.

The respondent failed to meet the appropriate standard of care in that the respondent did not adequately evaluate the patient's presenting condition, amenorrhea. Under the above circumstances, the appropriate standard of medical care requires that the OB/GYN order tests to confirm or rule out pregnancy. In addition, when, as above, the patient, who was amenorrheic, presents with one-sided pelvic pain, the physician should order tests to confirm or rule out an ectopic pregnancy. There is no indication in the record that the respondent ordered these confirmatory tests.

Further, the prescribing of Provera and/or oral contraceptives to patients who are pregnant or are possibly pregnant is contraindicated in that these drugs may have an adverse effect on pregnancy.

The patient then saw the respondent for prenatal care on January 31, 1990. The patient's LMP relative to this visit was December 15, 1989. The medical record indicates that the respondent saw the patient in March, April, May, June, and July 1990. The respondent did not appropriately monitor the patient's pregnancy. The appropriate standard of medical care requires that the OB/GYN order certain routine laboratory tests, including, but not limited to, an HBsAg test. The appropriate standard of medical care also requires that the OB/GYN order a repeat CBC at twenty-eight-weeks gestation to monitor the patient for such conditions as anemia or, more commonly, thrombocytopenia. In addition, the appropriate standard of medical care requires that the OB/GYN order a 50 gm glucose screening test at twenty-eight-weeks gestation to evaluate the patient for possible gestational diabetes. There is no indication in the medical record that the respondent ordered these tests in a timely fashion.

Patient P

Patient P, a 21-year-old female, sought gynecologic care from the respondent on one occasion, June 13, 1990. The respondent diagnosed the patient as having dysfunctional uterine bleeding (DUB), and noted that the patient had sickle cell anemia. The respondent ordered various tests, including a Pap smear, and scheduled a follow-up visit for the patient in three months.

The respondent failed to meet the appropriate standard of care in regard to this patient for the following reasons:

1. The medical record is inadequate. The appropriate standard of medical care requires that the OB/GYN, at a minimum, document a history of the patient; the patient's chief and secondary

complaints; objective findings, including the results of any physical examinations of the patient and the findings of any pertinent laboratory tests; an assessment of the patient; and a treatment plan.

The respondent did not adequately document the patient's history in the medical record. Documentation of a patient's history should include, but not be limited to, the patient's history of any present illnesses, past medical history, allergies, drug sensitivities, current medications, and family history. Because the medical record indicates that the patient had sickle-cell anemia, the treating physician should also include details about the patient's illness, including a history of the frequency of transfusions (and whether the patient was counseled in regard to the human immunodeficiency virus), and the frequency and type of crises the patient may have experienced as a result of the sickle-cell condition.

2. The respondent also did not document the results of a physical examination. Although the respondent conducted breast and pelvic examinations, there is no documentation in the medical record chart that the respondent performed a general physical examination of the patient.
3. In his assessment of the patient's condition, the respondent failed to substantiate the diagnosis entered in the chart, DUB. There is no description of abnormal bleeding patterns to substantiate a diagnosis of DUB. The appropriate standard of medical care requires that the treating physician document a medical rationale for the diagnosis.
4. The respondent did not order a treatment plan for the patient's condition. The appropriate standard of medical care requires that the physician, where possible, order a treatment plan to manage the patient's condition. The respondent did not order cycling with progestational medication or dilatation and curettage (D&C), or make any reference in the medical record as to why the above therapies were considered and rejected.

Notice of possible sanctions

If, after a hearing, the board finds that there are grounds for action under *Md. Health Occ. Code Ann.* §14-404(a)(22), the board may impose disciplinary sanctions against the respondent's license, including revocation, suspension, or reprimand, and may place the respondent on probation.

Notice of hearing, settlement conference, and prehearing conference

A hearing in this matter has been scheduled for October 3, 1991 at 1:00 p.m. in the Office of Administrative Hearings, Administrative Law Building, Greenspring Station, 10753 Falls Road, Lutherville, Maryland 21093.

In addition, a settlement conference in this matter has been scheduled for August 14, 1991 at 1:30 p.m. in the board's office, 4201 Patterson Avenue, Baltimore, Maryland 21215; and a prehearing conference in this matter has been scheduled for September 26, 1991 at 9:00 a.m. in the Office of Administrative Hearings, Administrative Law Building, Greenspring Station, 10753 Falls Road, Lutherville, Maryland 21093. The nature and purpose of the settlement conference and prehearing conference is described in the letter to the respondent.

ISRAEL H. WEINER MD, Chairperson
Maryland Board of Physician Quality Assurance

Board of Physician Quality Assurance Actions

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**In the matter of
Robert L. White
before the
Maryland Board of
Physician Quality Assurance
Consent order**

Having reviewed certain information which came to its attention, the Board of Physician Quality Assurance (the board), on February 27, 1991, voted to charge Robert L. White (the respondent), physician assistant, with the commission of a prohibited act under the Maryland Medical Practice Act (the act), *Md. Health Occ. Code Ann.* (HO) §15-314(3).

The pertinent provision of the act under HO §15-314(3) provides the following:

Subject to the hearing provisions of §15-315 of this subtitle, the board, on the affirmative vote of a majority of its members then serving, may reprimand any certificate holder or suspend or revoke a certificate if the certificate holder:

...commits any act which could serve as the basis for disciplinary action against a physician under §14-404 of this article.

The basis for disciplinary action under HO §14-404 is as follows:

...pleads guilty ... with respect to a crime involving moral turpitude ... [See HO §14-404(b)].

The respondent pleaded guilty on November 5, 1990 to three counts of violating *Md. Code Ann.* Art. 27§300, in which it was alleged that the respondent unlawfully obtained the prescription drug Stadol "by fraud, deceit, misrepresentation and subterfuge, to wit: by forging a prescription" during the period December 12, 1988 through July 11, 1989.

On May 22, 1991, a settlement conference was held with the following board members present: John F. Strahan, M.D., chief settlement officer; J. Andrew Sumner, M.D.; and Frank A. Gunther, Jr. Also present were the respondent; the respondent's spouse, Mrs. White; P. Paul Cocoros, Esquire, counsel for the respondent; Robert J. Gilbert, assistant attorney general, administrative prosecutor; and Barbara Hull Foster, assistant attorney general, counsel to the board. As a result of the discussions at the settlement conference, the settlement conference members recommended that the board resolve this case by entering into the following consent order. At its meeting on Wednesday, June 26, 1991, the board considered the settlement conference's recommendation and agreed to the following Consent Order.

Findings of fact

1. At all times relevant to these charges, the respondent was and is certified to practice as a physician assistant in the state of Maryland.
2. On or about September 19, 1990, the respondent was

charged in the matter of *State of Maryland v Robert Lee White, Jr.*, under Case Number 660849CO, with ten counts of violating *Md. Code Ann.* Art. 27, §300, in which it was alleged that the respondent unlawfully obtained various prescription drugs, such as Stadol, Pyridiate, and Buprenex "by fraud, deceit, misrepresentation, and subterfuge, to wit: by forging a prescription" during the period December 12, 1988 through July 11, 1989, all occurring at Drug City, a pharmacy located at 2805 North Point Boulevard in Baltimore County, Maryland.

3. On or about November 5, 1990, the respondent appeared in the District Court for Baltimore County, Dundalk, Maryland, the Honorable Thomas Bollinger presiding, in regard to the aforementioned charges. On this date, the respondent, after engaging in plea negotiations with the assistant state's attorney for Baltimore County, entered guilty pleas to three counts of violating *Md. Code Ann.* Art. 27, §300, in which it was alleged that on three occasions, December 12, 1988, January 8, 1989, and January 14, 1989, the respondent unlawfully obtained Stadol, a prescription drug, through fraud, by forging prescriptions (see section two above). Sentencing was deferred pending a pre-sentence investigation of the respondent.
4. On or about February 21, 1991, the respondent appeared for sentencing on the aforementioned charges in the District Court for Baltimore County, Towson, Maryland, the Honorable G. Darrell Russell presiding. The respondent was granted probation before judgment under *Md. Code Ann.* Art. 27, §641 as to the three counts of the aforementioned charges. The respondent was fined \$100 on each count, for a total of \$300.
5. Under the terms and conditions of probation before judgment under *Md. Code Ann.* Art. 27, §641(a)(4), an individual who has received a stay of entering of the judgment waives the right to appeal from the judgment of guilt by the court at any time.
6. The crime of unlawfully obtaining a prescription drug by fraud, deceit, misrepresentation, or subterfuge by the forging of a prescription order, under *Md. Code Ann.* Art. 27, §300, as described in paragraphs two, three, and four above, is a crime involving moral turpitude under the act.

Conclusions of law

Based on the foregoing findings of fact, the board concludes that the respondent has pleaded guilty to a crime involving moral turpitude. Accordingly, the board concludes as a matter of law that the respondent has violated HO §§15-314 and 14-404(b).

Order

Based on the foregoing findings of fact and conclusions of law, it is this 23rd day of July 1991, by the board, hereby

Board of Physician Quality Assurance Actions

ORDERED, that pursuant to the authority vested in the board under HO §15-314(3), the respondent's certification to practice as a physician assistant in the state of Maryland is hereby **SUSPENDED** for a period of three months from the date of this order, that date being the date the board signs this order; and be it further

ORDERED, that the respondent immediately shall surrender to the board his physician assistant certification, wall license, and any renewal cards; and be it further

ORDERED, that the respondent, in the event that he intends to seek reinstatement of his certification to practice as a physician assistant, must, at the conclusion of the period of suspension, petition the board for recertification as a physician assistant, i.e., must fill out a new application for certification; and be it further

ORDERED, that at the conclusion of the period of suspension, the respondent, in the event that he intends to seek reinstatement, and after following the procedures outlined above, shall be placed on probation for a period of three years, subject to bi-annual reports from the respondent's supervising physician(s) as to his performance; and be it further

ORDERED, that, in the event that the respondent's certification to practice as a physician assistant is reinstated by the board, the board shall notify the respondent's supervising physician(s) of this consent order; and be it further

ORDERED, that any public disclosure of the foregoing shall consist of the contents of this **CONSENT ORDER** as permitted by *State Gov't. Code Ann. §10-617(h)*.

ISRAEL H. WEINER MD, Chairperson
Maryland Board of Physician Quality Assurance

Consent

I, Robert L. White, Jr., acknowledge that I am represented by legal counsel and have had an opportunity to consult with counsel before entering into and signing this document. By this consent, I hereby admit the truth of the findings of fact, conclusions of law, and accept and submit to the foregoing consent order and its conditions, consisting of eight pages.

I acknowledge the validity of this consent order as if entered after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by the laws of the state of Maryland. I acknowledge the legal authority and the jurisdiction of the board to initiate these proceedings and to issue and enforce this consent order. I also recognize that I am waiving my right to appeal any adverse ruling of the board that might have followed any such hearing.

I sign this order after having an opportunity to consult with counsel, without reservation, and I fully understand and comprehend the language, meaning, and terms of this consent order.

ROBERT L. WHITE

National Library Week

April 5-11, 1992

and

International Special Librarians Day

April 9, 1992

Since 1958 the American Library Association and related organizations have celebrated National Library Week to encourage reading and the continued wide availability of books. This year, National Library Week's theme is "Your right to know. Librarians make it happen." This emphasizes one of our most basic democratic freedoms and the library's key role in ensuring access to information for all.

Beginning in 1991, the Special Libraries Association further designated one day of National Library Week as International Special Librarians Day. This year the day falls on April 9 and the theme is "Information knows no bounds."



EPIDEMIOLOGY & DISEASE CONTROL PROGRAM
201 W. Preston Street, Baltimore, Maryland 21201 (410)225-6700

Nelson J. Sabatini - Secretary
Department of Health & Mental Hygiene

J. Mehnen Joseph, PhD - Director
Community Health Surveillance & Laboratories Admin.

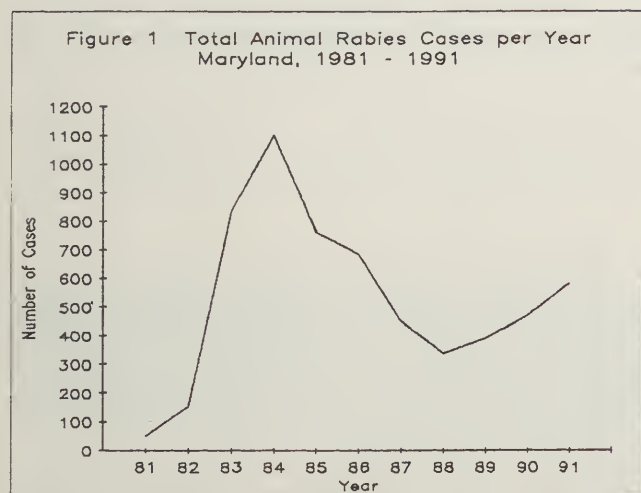
Ebenezer Israel, MD, MPH - Director
Epidemiology & Disease Control Program

Rabies, 1991, and Universal Infant Hepatitis B Vaccine / Postexposure Prophylaxis for Hepatitis B April, 1992

Animal Rabies in Maryland, 1991

In 1991, Maryland again was third in the United States in laboratory confirmed animal rabies (579), behind the more recently involved states of New York and New Jersey, and ahead of Texas and California.

Figure 1 shows the number of animals identified as having rabies in Maryland from 1981 to 1991. In 1991, there were 111 more cases of animal rabies than in 1990 (24% increase) and an additional 241 (71% increase) over the low of 1988. Confirmed animal rabies peaked in 1984 with 1100 cases as the result of an epizootic (animal epidemic) which involved several populous counties of Central Maryland over a short time. There has been no human rabies in Maryland during the epizootic since it began in 1981.



In 1991, 207 of the rabid animals were from the Eastern Shore counties located entirely below the Chesapeake and Delaware Canal (i.e., Kent, Queen Anne's, Caroline and Talbot Counties), up from 108 in 1990. In August, 1986, wildlife rabies slowly began advancing around the northern end of the Chesapeake Bay in Cecil County. Kent County became involved in October, 1989, and Caroline and Queen Anne's in 1990. Talbot County had its first rabid racoon found in February, 1991. In 1991, Kent had a total of 20 cases, Caroline 56, Queen Anne's 77, and Talbot 54.

Seven jurisdictions west of the Chesapeake Bay reported significant increases in 1991. Those counties were Allegany 4 (36% increase), Anne Arundel 30 (111%), Carroll 6 (50%), Frederick 40 (143%), Montgomery 8 (35%), St. Mary's 1 (25%) and Washington 14 (88%). Because these counties had been originally involved in the epizootic 6 to 11 years ago, these increases represent an apparent cyclic recovery of the racoon population and an increase in susceptibles that are now getting rabies.

Raccoon rabies accounted for 467 (80.7%) of the 579 cases in 1991. All other species with rabies, except the bat, are regarded as spillover from the maintenance host, the racoon. There is no evidence of transmission within the various spillover species. Fox cases (18, 3.1%), skunk (51, 8.8%), groundhog (10, 1.7%), bat (12, 2.2%) and beaver (1, 0.2%) changed little in percentage of confirmed cases. Similarly, domestic animals varied very little from the previous year, with 15 cats (2.6%), 2 dogs (0.4%), 1 bovine (0.2%) and 1 horse (0.2%) being confirmed rabid. Of the domestic animals, cats continue to represent the greatest risk of exposure to humans. In addition to a higher number of cats being rabid (15 as compared to 2 rabid dogs), each cat exposes

more humans. The reason for this is not clear although the cat may be less often suspected as rabid. For example, a stray cat (especially a kitten) is likely to invoke a person's pity; the person may misinterpret early signs of rabies as extraordinary friendliness, helplessness, or injury of an otherwise untame cat.

The threat of rabies from human exposure to raccoons is clear. Less often recognized is the fact that the groundhog shares burrows with the raccoon. That is peculiar to the raccoon epizootic and results in unusually high numbers of rabid groundhogs. This is not the case in epizootic rabies in which the fox or skunk is the maintenance host. Since 1981, Maryland has recorded 59 rabid groundhogs as contrasted with a total of 18 other miscellaneous wild animals.

Rabies Deaths in the United States, 1991

Three human rabies deaths were reported in the United States in 1991. The following case reports are excerpted from: CDC, Human Rabies - Texas, Arkansas, and Georgia, 1991. MMWR 1991; 40, 44: 765-769.

Patient 1. A woman from a county in Texas bordering Mexico died 13 days after onset of nervousness, shortness of breath, difficulty swallowing, followed by aerophobia, hydrophobia, and ascending paresis. Rabies was considered in the differential diagnosis on the 5th day. A nape of the neck biopsy was negative on that day but by the 10th day CDC detected rabies virus in the saliva. On the 12th day a second biopsy was positive by DFA. Monoclonal antibody typing showed an isolate identical to the virus strain found in dogs in Mexico and along the border of Mexico and Texas where rabies is endemic in dogs and coyotes. The woman had no known exposure to rabies. Possible exposure to this woman resulted in 43 persons receiving postexposure prophylaxis.

Patient 2. On August 17 an Arkansas man had onset of sore throat, headache and two days later swallowing difficulty. The same day he became anxious, tearful, and his facial muscles were twitching. Upon hospitalization that evening he was alert and oriented and, although he gave no history of animal bites, rabies was considered. Later he complained of itching, gagging sensation and became agitated and photophobic. He died on the 9th day. Postmortem samples of brain tissue were positive for rabies by DFA. Subsequent monoclonal antibody typing at CDC suggested a rabies variant common in the silver-haired bat.* A friend of the patient reported that in early July a bat had landed on the man's face who killed and disposed of it. Others recalled the patient had told of bites on his thumb or scratches on his chest. A total of 99 persons who had possible exposure to the patient from two weeks before onset received postexposure prophylaxis.

Patient 3. A Georgia woman developed sore throat, headache, and fever and was treated with parenteral antibiotics. Two days later she was admitted to a local

hospital with painful swallowing, agitation, and fever of 40°C. Rabies was considered in the differential diagnosis at a referral hospital. Her condition continued to deteriorate and she died on the 7th day. Rabies was confirmed at postmortem by DFA. Monoclonal antibody typing at CDC suggested the same rabies variant as isolated from patient 2. There was no known animal exposure.

Comment: Rabies postexposure prophylaxis is recommended for all persons bitten or scratched by wild or domestic animals that may be carrying the disease. Exposures other than bites or scratches rarely result in infection. However, postexposure treatment is recommended for persons who report having an open wound or mucous membrane contaminated with saliva or other potentially infectious material (e.g., brain tissue) from a rabid animal. Since the size of bites by bats may be small in comparison to those inflicted by terrestrial animals, it may be prudent to consider postexposure treatment for physical contact with bats when a bite or mucous membrane exposure cannot be excluded. Treatment should always be initiated as soon as possible after bites or scratches by known or suspected rabid animals occur.

*Note: The silver-haired bat (*Lasiurus noctivagus*) also breeds in the Allegheny Mountain section of Maryland but occurs in all areas of the state as a migrant. It is a colonial bat which roosts in small groups in hollow trees, dense foliage and occasionally buildings.

Animal bites are reportable to your local health department in Maryland. All local health departments or the Maryland Department of Health and Mental Hygiene can be contacted for consultation on postexposure prophylaxis against rabies.

Hepatitis B: Universal Vaccination of Infants Born to HBsAg-Negative Mothers

Hepatitis B vaccination is recommended for all infants, regardless of the HBsAg status of the mother. Hepatitis B vaccine should be incorporated into vaccination schedules for children. The first dose can be administered during the newborn period, preferably before the infant is discharged from the hospital, but no later than when the infant is 2 months of age (Table 1). Because the highest titers of anti-HBs are achieved when the last 2 doses of vaccine are spaced at least 4 months

apart, schedules that achieve this spacing may be preferable. However, schedules with 2-month intervals between doses, which conform to schedules for other childhood vaccines, have been shown to produce a good antibody response and may be appropriate in populations in which it is difficult to ensure that infants will be brought back for their vaccinations. The development of combination vaccines containing HBsAg may lead to other schedules that will allow optimal use of combined antigens.

TABLE 1. Recommended schedules of hepatitis B vaccination for infants born to HBsAg*-negative mothers

Hepatitis B vaccine	Age of infant
Option 1	
Dose 1	Birth—before hospital discharge
Dose 2	1-2 months [†]
Dose 3	6-18 months [†]
Option 2	
Dose 1	1-2 months [†]
Dose 2	4 months [†]
Dose 3	6-18 months [†]

*HBsAg = Hepatitis B surface antigen.

[†]Hepatitis B vaccine can be administered simultaneously with diphtheria-tetanus-pertussis, *Haemophilus influenzae* type b conjugate, measles-mumps-rubella, and oral polio vaccines at the same visit.

The recommended dose of hepatitis B vaccine when given to infants of HBsAg negative mothers is 0.25 ml for Recombivax HB (Merck, Sharp & Dohme) and 0.5 ml for Engerix-B (Smith-Kline and French).

Postexposure Prophylaxis for Hepatitis B

Acute Exposure to Blood That Contains (or Might Contain) HBsAg

For inadvertent percutaneous (needle stick, laceration, or bite) or permucosal (ocular or mucous membrane) exposure to blood, the decision to provide prophylaxis must include consideration of several factors: a) whether the source of the blood is available; b) the HBsAg (hepatitis B surface antigen) status of the source; and c) the hepatitis B vaccination and vaccine-response status of the exposed person. Such exposures usually affect persons for whom hepatitis B vaccine is recommended. For any exposure of a person not previously vaccinated, hepatitis B vaccination is recommended.

After any such exposure, a blood sample should be obtained from the person who was the source of the exposure and should be tested for HBsAg. The hepatitis B vaccination status and anti-HBs (hepatitis B surface antibody) response status (if known) of the exposed person should be reviewed. The outline below and Table 2 summarize prophylaxis for percutaneous or permucosal exposure to blood according to the HBsAg status of the source of exposure and the vaccination status and vaccine response of the exposed person.

For greatest effectiveness, passive prophylaxis with HBIG, when indicated, should be administered as soon

as possible after exposure since its value beyond 7 days after exposure is unclear.

I. Source of exposure HBsAg-positive

- Exposed person has not been vaccinated or has not completed vaccination. Hepatitis B vaccination should be initiated. A single dose of HBIG (Hepatitis B Immune Globulin) (0.06 mL/kg) should be administered as soon as possible after exposure and within 24 hours, if possible. The first dose of hepatitis B vaccine should be administered intramuscularly at a separate site (deltoid for adults) and can be administered simultaneously with HBIG or within 7 days of exposure; subsequent doses should be administered as recommended for the specific vaccine. If the exposed person has begun but has not completed vaccination, one dose of HBIG should be administered immediately, and vaccination should be completed as scheduled.
- Exposed person has already been vaccinated against hepatitis B, and anti-HBs response status is known.
 - If the exposed person is known to have had adequate response in the past, the anti-HBs level should be tested unless an adequate level has been demonstrated within the last 24 months. Although current data show that vaccine-induced protection does not decrease as

antibody level wanes, most experts consider the following approach to be prudent:

- a) If anti-HBs level is adequate, no treatment is necessary.
 - b) If anti-HBs level is inadequate, a booster dose of hepatitis B vaccine should be administered. (An adequate antibody level is ≥ 10 mIU/mL.)
- (2) If the exposed person is known not to have responded to the primary vaccine series, he or she should receive either a single dose of HBIG and a dose of hepatitis B vaccine as soon as possible after exposure, or two doses of HBIG (0.06 mL/kg), one given as soon as possible after exposure and the second 1 month later. The latter treatment is preferred for those who have not responded to at least four doses of vaccine.
- c. Exposed person has already been vaccinated against hepatitis B, and the anti-HBs response is unknown. The exposed person should be tested for anti-HBs.
- (1) If the exposed person has adequate antibody, no additional treatment is necessary.
 - (2) If the exposed person has inadequate antibody on testing, one dose of HBIG (0.06 mL/kg) should be administered immediately and a standard booster dose of vaccine administered at a different site.

2. Source of exposure known and HBsAg-negative

- a. Exposed person has not been vaccinated or has not completed vaccination. If unvaccinated, the exposed person should be administered the first dose of hepatitis B vaccine within 7 days of exposure, and vaccination should be completed as recommended. If the exposed person has not completed vaccination, vaccination series should be completed as scheduled.
- b. Exposed person has already been vaccinated against hepatitis B. No treatment is necessary.

3. Source of exposure unknown or not available for testing

- a. Exposed person has not been vaccinated or has not completed vaccination. If unvaccinated, the exposed person should be administered the first dose of hepatitis B vaccine within 7 days of exposure, and vaccination should be completed as recommended. If the exposed person has not completed vaccination, vaccination should be completed as scheduled.
- b. Exposed person has already been vaccinated against hepatitis B, and anti-HBs response status is known.
 - (1) If the exposed person is known to have had adequate response in the past, no treatment is necessary.
 - (2) If the exposed person is known not to have responded to the vaccine, prophylaxis as described earlier in section 1.b(2) under

"Source of exposure known HBsAg-positive" may be considered if the source of the exposure is known to be at high risk of HBV infection.

- c. Exposed person has already been vaccinated against hepatitis B, and the anti-HBs response is unknown. The exposed person should be tested for anti-HBs.

- (1) If the exposed person has adequate anti-HBs, no treatment is necessary.
- (2) If the exposed person has inadequate anti-HBs, a standard booster dose of vaccine should be administered.

TABLE 2. Recommendations for hepatitis B prophylaxis following percutaneous exposure

Exposed person	Treatment when source is found to be		Unknown or not tested
	HBsAg positive	HBsAg negative	
Unvaccinated	Administer HBIG x 1* and initiate hepatitis B vaccine†	Initiate hepatitis B vaccine†	Initiate hepatitis B vaccine†
Previously vaccinated			
Known responder	Test exposed person for anti-HBs 1. If adequate, no treatment 2. If inadequate, hepatitis B vaccine booster dose	No treatment	No treatment
Known non-responder	HBIG x 2 or HBIG x 1, plus 1 dose of hepatitis B vaccine	No treatment	If known high-risk source, may treat as if source were HBsAg positive
Response unknown	Test exposed person for anti-HBs‡ 1. If inadequate, HBIG x 1, plus hepatitis B vaccine booster dose 2. If adequate, no treatment	No treatment	Test exposed person for anti-HBs‡ 1. If inadequate, hepatitis B vaccine booster dose 2. If adequate, no treatment

*Hepatitis B immune globulin (HBIG) dose 0.06 mL/kg intramuscularly.

†Hepatitis B vaccine dose—see Table 1.

‡Adequate anti-HBs is ≥ 10 milli-international units.

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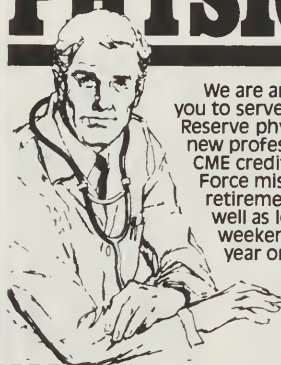
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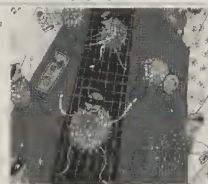
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Rosemary Hatem Bonsack, M.D., a member of the Harford County delegation to the Maryland General Assembly, was appointed chairperson of the Medical/Professional Liaison Subcommittee of the State Council of Cancer Control in January 1992. The subcommittee will monitor the expansion in the number of providers who offer integrated programs for the early de-

tection, referral, and follow-up treatment of breast and cervical cancer, and for the cessation of tobacco use under the Maryland Cancer Control Implementation Plan. The subcommittee is also charged with: increasing the number of physicians and other health care professionals who refer and follow women for mammograms and who perform or refer and follow women for Pap tests and clinical breast exams; promoting the increase in the number of physicians and other health care professionals who advise their patients to quit smoking; promoting as a standard, accredited, dedicated low-dose, and high quality mammography; and promoting the use of standardized terminology for reporting the findings of mammography and Pap test cytology. Also in January 1992, Dr. Bonsack was appointed chairperson of the Chapter Affairs Committee of the American Academy of Family Physicians (AAFP). Dr. Bonsack is also an alternate delegate to the AAFP Congress of Delegates from the state of Maryland.



Mukund S. Didolkar, M.D. was recently appointed director of the Surgical Oncology Program at the Sinai Hospital of Baltimore. A graduate of Nagpur University in India and the Royal College of Surgeons in England, Dr. Didolkar is a prolific author, having published more than seventy-five articles, books, and editorials, as well as having produced a number of films on cancer-related topics. Well-known as a public speaker, Dr. Didolkar is a board-certified surgeon who has taught at Nagpur University in India, the University of Manchester in the United Kingdom, the Roswell Park Memorial Institute in New York, the University of South Dakota Medical School, the State University of New York, and the University of Maryland. Active in numerous professional societies, he is winner of numerous awards and honors. Dr. Didolkar is married to Shaila Didolkar, M.D., F.A.C.O.G.; they have two children.



Arthur Kaufman, M.D. recently received a certificate of achievement from The Johns Hopkins National Search for

Computing to Assist Persons with Disabilities. Dr. Kaufman's PlusTag Magic Medical Record System was selected as one of the top thirty entries from a field of over 750 and, as such, was exhibited at the Smithsonian Institution. (PlusTag is a rugged, wearable card in the form of a dog tag that can be programmed to

carry a patient's medical record, including the most recent x-ray and electrocardiogram. It is intended to aid persons who, because of their disabilities, are unable to provide medical information about themselves in an emergency.) Dr. Kaufman received his bachelor's degree in sociology from Duke University, his master's degree in industrial organic chemistry from the Brooklyn Polytechnic Institute, and his medical degree from the State University of New York. Past medical director and vice-president of Forensic Medical Advisory Service, Inc., he has long been interested in quality assurance and in health care in the prison system. Dr. Kaufman has been active at the committee level for both Med Chi and the Prince George's County Medical Society. A family practitioner, Dr. Kaufman has for years been combining his interest in computer technology with his knowledge of medicine, having developed not only PlusTag but a number of computerized utilization review programs. He is currently associated with Computer Assisted Medical Solutions, Inc. in Bethesda, Maryland.



Richard M. Susel, M.D., F.A.C.S. has assumed the post of president of the St. Agnes Hospital Medical Staff after serving a one-year term as president-elect. He is also chief of the Section of Ophthalmology at St Agnes, as well as clinical assistant professor of ophthalmology at the University of Maryland Medical School, and instructor and lecturer at the Wilmer Institute. A

graduate of the University of Maryland, Dr. Susel is certified by the American Board of Ophthalmology, and is a Fellow of both the American College of Surgeons and the American Academy of Ophthalmology. From 1982 to 1987, Dr. Susel served as medical director of Tissue Bank International, and is currently a member of the Board of Trustees. He presently serves as chairperson of Med Chi's ad hoc Therapeutic and Formulary Committee. A member of the American Academy of Ophthalmology and the Maryland Society of Eye Physicians and Surgeons, he is the author of publications regarding corneal preservation and keratoplasty evaluation.



The nightmare of leech attacks while trekking in Nepal

I hope you never find yourself in leech-infested areas as I did recently while trekking in Nepal. The leech, a predacious or parasitic annelid worm of the phylum Annelida, class Hirudinea, is characterized by a cylindrical or slightly flattened body with suckers at either end for attaching to prey. Like other annelids, the leech is segmented but its numerous surface folds obscure its internal segments. In many forms, the mouth has three small jaws equipped with sharp teeth. The digestive tract has lateral pouches that hold enough of the leech's staple food—blood—to last for months. The reproductive system is complex; leeches are hermaphroditic and cross-fertilizing. Nearly all leeches are aquatic, abounding in freshwater ponds in temperate regions. Some are permanent parasites of man, horse, cattle, fish, and mollusks, but most are merely predatory. The salivary secretions of the leech contain hirudin, an anticoagulant. Medicinal leeches, once used by physicians to bleed patients suffering from almost any ailment, are now used in some parts of the world for the treatment of bruises such as black eyes. Certain small leeches of the eastern Mediterranean region may enter the bodies of humans and animals through drinking water and lodge as parasites in the mouth or the respiratory passages.

I asked a number of people about the best defense against leeches. I was told that I should keep my trousers tucked in my socks, that it was unlikely that insect repellents would work (as repellents probably only worked against mosquitos and other flying insects), and that if a leech were to attach itself to me, I should touch a lighted cigarette to the back of the leech in order to make it release its bite. So when the heavy rains came unexpectedly to the area in which my colleagues and I were trekking and leeches appeared literally by the millions, we found ourselves with virtually no defenses.

The leeches ranged in size from about one quarter inch to six inches. They were as thin as a matchstick before they sucked our blood and as swollen as a cigarette after. If I have nightmares, I know the villains will be those whitish creatures! They would inch up our shoes, legs, and bodies. I found one full of blood on my head. Evolution has been so successful in preparing them for their bloodsucking that it was rare that we could feel by touch when they crawled over our skin. Only by sight could we find them. Frequently, there were thirty or more on each of us at any instant. We were pulling off thousands of them in a few hours. My guide, who was Nepalese and had holes in his shoes, was bleeding profusely and was slushing blood in his socks. My own socks were also soaked with blood. Even after we removed the leeches from our bodies, we continued to bleed for one-half hour or longer. It was so hot that if we kept our trousers on,

we just poured sweat, but trousers did offer some leech protection. If we took our trousers off, we got leeches up and down our exposed legs, although we were a little cooler—it seemed hopeless.

It was going to take more than one hour to get out of the leech area. We were in Nepal, between Dhamdus and Nuanda, more or less 100 miles west of Katmandu. In desperation, the thought occurred to me—what do I have to lose by using my insect repellent that I was carrying for mosquitoes and flying insects? The leeches withered, twisted, and fell off when touched by *Jungle Juice* by REI, and we began to smear it on over clothes and shoes. The leeches would now climb up on our shoes and fall away, and we experienced a great sense of relief. I am passing this information on to editors of several medical journals I read and to travel agent friends who have clients going to leech-infested areas, hoping the good news will spread. (I hope this does not release a deluge of letters from animal rights groups, who attack me for killing leeches.) I have also contacted the president of REI and suggested that the company add leeches to the insects *Jungle Juice* can repel.

I will be happy if this information prevents one or more people from suffering a leech experience such as I survived. The film *African Queen* portrays something of how it felt.

My second purpose is to inquire if any medical care providers, physicians, pharmacists, or nurses know what is being done to help the Nepalese address health problems? "One-fifth of the babies do not survive beyond the first few weeks of life, men live an average of 44 years, and women hardly three more," according to *Our World in Colour Nepal*, one of the most beautiful and pleasing books I've ever enjoyed (published by Publishers Group West, Inc., 4065 Hollis, Emeryville, California 94608). (*Nepal*, published by The Lively Plant, POB 2001A, Berkley, California 94702 is also almost indispensable as part of your travel survival kit.)

I am considering volunteering or helping organize physician volunteers. Right now, I am just gathering information. If any reader would like a summary of what I have learned by about this time next year, please send a large self-addressed, postage-paid envelope to Charles Farwell, M.D., 11406 Viers Mill Rd., Wheaton, MD 20902-2574. My next trip to Nepal will be in October/November 1992, and I will gladly mail anyone what I have learned from organizations like Hope, American Friends Service Committee, World Health Organization, and others by February 1993.

CHARLES FARWELL, M.D.

Dr. Farwell is a family practitioner from Wheaton, MD. ■

The Johns Hopkins Medical Institutions

All courses at the Turner Auditorium unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Education, 720 Rutland Ave., Baltimore, MD 21205 (410-955-2959).

- 4th Baltimore perinatal colloquium.** 23 Cat 1 AMA/PRA credits; ACOG cognates available. Fee: \$450 physicians; \$250 residents. **Apr. 1-4**
- J. Donald Woodruff symposium on gynecologic oncology,** at the Marriott Inner Harbor Hotel, Baltimore, MD. Cat 1 AMA/PRA credit available. **Apr. 9-11**
- Do not resuscitate and beyond: Life and death decision making.** Cat 1 AMA/PRA credits available. Fee: \$75. **Apr. 13**
- Basic concepts in dysphagia diagnosis and management.** Cat 1 AMA/PRA credits available. Fee: \$125 physicians; \$95 residents and allied health professionals. **Apr. 22**
- Fourth multidisciplinary symposium on dysphagia.** Cat 1 AMA/PRA credits available. Fee: \$400 physicians; \$225 residents and allied health professionals. **Apr. 23-24**
- Pediatric allergy and immunology for the practitioner.** Cat 1 AMA/PRA credit available. **May 7-8**
- The Philip A. Tumulty topics in clinical medicine 1992.** 38 Cat 1 AMA/PRA credits. Fee: \$650 physicians; \$400 residents and allied health professionals. **May 11-15**
- The 5th summer institute in environmental health studies.** Info: Dr. Jacqueline Corn or Catherine Walsh, 410-955-2609. **May 18-29**
- Symposium on the prevention of developmental disabilities in infants and toddlers.** 14 Cat 1 AMA/PRA credits. Fee: \$200 physicians; \$100 residents, fellows, and allied health professionals. **June 4-5**

Continuously throughout the year

- Visiting preceptorship in pediatric critical care medicine.** Ongoing five-day preceptorship by appointment. 40 Cat 1 AMA/PRA credits. Fee: \$600.
- Ophthalmic electrophysiology technician training course.** Ongoing one-week course by appointment. The Wilmer Eye Institute, Baltimore, MD.
- Ophthalmology grand rounds.** Audiovisual continuing education series of case discussions for clinicians; 3-8 topics per conference. Thursdays, 7:30-9:00 a.m. 2 Cat 1 AMA/PRA credits per session. Info: 410-955-5700.
- Neuro-ophthalmology conference.** Held twice per month. Info: 410-955-5700.
- Cornea conference.** Held monthly. Info: 410-955-5700.
- The department of radiology and radiological sciences** offers several courses in abdominal and obstetrical ultrasound. Info: P. Williams 410-955-3169.
- Visiting physicians.** Offered throughout the year for experience in the lab and participation in read-in sessions; by appointment only. 40 Cat 1 AMA/PRA credits. Fee: \$500.
- Johns Hopkins medical grand rounds.** Accredited audiovisual continuing education series of case discussions for clinicians; thirty topics per year in five bimonthly programs. Individual and group subscriptions. 40 Cat 1 AMA/PRA credits. Info: 410-955-3988.
- Microsurgery training at the Johns Hopkins Hospital.** One-week program offered continuously throughout the year. 40 Cat 1 AMA/PRA credits. Info: P. Williams 410-955-3169.

University of Maryland

For each course, additional information may be obtained by contacting the Program of Continuing Education, University of Maryland School of Medicine, Room 14-011, BRB, 655 W. Baltimore St., Baltimore, MD 21201 (410-328-3956) or by calling the phone number listed after a specific program. FAX 410-328-3103.

Current cancer therapy symposium. Info: Sharon Stenhouse, 410-328-3956.	Apr. 3
HIV counseling skills I , sponsored by the Maryland AIDS Professional Education Center, in Cambridge, MD. Info: Sylvia Scherr, 410-328-8639.	Apr. 6-7
Power and medical ethics: The Ipolitas Benedict Bronushas lecture , at the R.A. Cowley Shock Trauma Conference Center Auditorium. Info: 410-448-2770.	Apr. 10
Infectious diseases in everyday medicine: Second annual symposium , at the Baltimore Convention Center, Baltimore, MD. 12 Cat 1 AMA/PRA credits. Fee: \$200 physicians; \$75 residents and students. Info: Eunice Katz, 410-328-7560.	Apr. 23-24
Advanced laparoscopic general surgery , in Towson. 16 Cat 1 AMA/PRA credits. Fee: \$3,300. Info: Pat Rahmiow, 410-321-5481.	Apr. 24-25 and May 15-16
HIV counseling supervisory skills , sponsored by the Maryland AIDS Professional Education Center, in Annapolis, MD. Info: Sylvia Scherr, 410-328-8639.	May 4-5
Pediatric HIV clinical preceptorships , sponsored by the Maryland AIDS Professional Education Center, in Baltimore, MD. Info: Sylvia Scherr, 410-328-8639.	May 5
Subspecialty care in general pediatric practice , at the University Club, UMAB campus, Baltimore, MD. 1 Cat 1 AMA/PRA credit. Fee: \$50. Info: Richard Ringel, M.D., 410-328-6666.	May 5
12th annual Abraham H. Finkelstein memorial lecture. Info: Bonnie Winters, 410-328-6777.	May 8
HIV: New frontiers for mental health — The triple diagnosed client , sponsored by the Maryland AIDS Professional Education Center, in Columbia, MD. Info: Sylvia Scherr, 410-328-8639.	May 15
HIV coordinator skills course , sponsored by the Maryland AIDS Professional Education Center, in Hagerstown, MD. Info: Sylvia Scherr, 410-328-8639.	May 21-22
AIDS, women and reproduction: Medical, legal and ethical challenges , sponsored by the Maryland AIDS Professional Education Center, in Baltimore, MD. Info: Sylvia Scherr, 410-328-8639.	June 11
18th annual family medicine review course , in Ocean City, MD. 26.5 Cat 1 AMA/PRA credits. Fee: \$395. Info: Sharon Stenhouse, 410-328-3956.	June 21-26
11th annual update in obstetrics and gynecology , in Annapolis, MD. Info: Sharon Stenhouse, 410-328-3956.	June 25-26

Continuously throughout the year

- Visiting professor program.** A 1992 directory of speakers and their topics is available to area hospitals and other health care organizations. NO administrative fees are charged for this service. Info: 410-328-3956.
- Departmental rounds and conferences.** Weekly, hands-on, and lecture presentations hosted by the University's clinical departments. Hour-for-hour Cat 1 AMA/PRA credits available. Brochure available.
- Pediatric grand rounds.** Every Thursday from September to June, except third Thursday, in the R. Adams Cowley Shock Trauma Auditorium. Info: Bonnie Winters, 410-328-6777.

Miscellaneous meetings

- | | |
|---|------------------------|
| The sixth annual review and update course in critical care medicine , sponsored by the Center for Bio-Medical Communication, Inc., at the Hyatt Regency-Capitol Hill, Washington, DC. 35 Cat 1 AMA/PRA credits. Info: Svetlana Lisanti, 201-385-8080. | Apr. 22-26 |
| Mini-invasion and megatreatments: Med Chi's 194th annual meeting , at the Omni Inner Harbor Hotel, Baltimore, MD. Info: Betsy Newman, 410-539-0872 or 1-800-492-1056. | Apr. 30 – May 2 |
| The annual meeting of the Virginia Society of Otolaryngology—Head and Neck Surgery , at the Boar's Head Inn, Charlottesville, VA. Info: Donna Scott, 804-353-2721. | May 1-2 |
| Trauma is no accident: 92/societal violence—A national epidemic , sponsored by the American Trauma Society, at the McLean Hilton, McLean, VA. Info: 800-556-7890. | May 6 – 8 |
| Rural health: Caring for the country , sponsored by the National Rural Health Association, at the Hyatt Regency Crystal City Hotel, Washington, DC. Info: Robert Quick, 816-756-3140. | May 6 – 9 |
| Clinical auscultation of the heart , sponsored by the American College of Cardiology, at the Georgetown University Medical Center, Washington, DC. 18 Cat 1 AMA/PRA credits. Info: Registration secretary, 800-257-4739. | May 13-15 |
| 44th annual meeting and scientific session of the Maryland Academy of Family Physicians , at the Sheraton Ocean City Resort and Conference Center, Ocean City, MD. 30.75 Cat 1 AMA/PRA credits; 30.75 AAFP prescribed hours. Fee: \$195 MAFP members; \$225 nonmembers; \$110 paramedicals; free for residents, medical students, and MAFP retired and life members. Info: Francis C. Bruno, M.D., 410-747-1980. | May 13-17 |
| Virginia Society of Ophthalmology annual meeting , at the Marriott, Richmond, VA. Info: Donna Scott, 804-353-2721. | May 15-16 |
| Revitalization for emergency professionals and spouses , sponsored by the Maryland Chapter, American College of Emergency Physicians, at the Morrison House Hotel, Alexandria, VA. Fee: \$175 physicians; \$25 spouses with physician. Info: 410-727-2237. | May 16 |

Shady Grove Adventist Hospital

9901 Medical Center Drive, Rockville, MD. Info: 301-279-6115.

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| Advances in management of testicular tumors. | Apr. 2 |
| Risk management. | Apr. 9 |
| Psychosocial aspects of caring for the cancer patient. | Apr. 23 |
| Overview of the new angiography suite at SGAH. | Apr. 30 |
| Estrogen replacement. | May 7 |
| Sleep disorders: Neurological perspective. | May 14 |
| Fundus exam and systemic disease. | May 21 |
| The challenge of chronic lymphedema. | May 28 |
| Performing arts medicine. | June 4 |
| Smoking cessation. | June 11 |
| Noninvasive assessment of coronary artery disease. | June 18 |
| Dangerous marine organisms. | June 25 |

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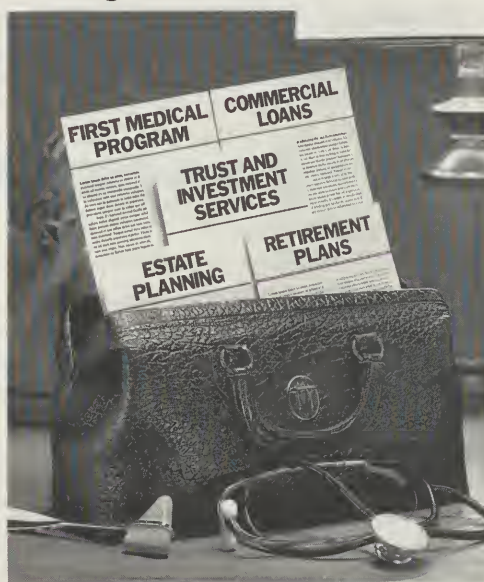
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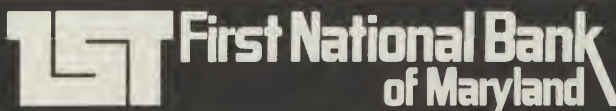


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monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

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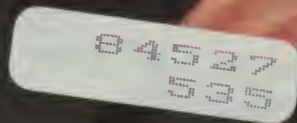
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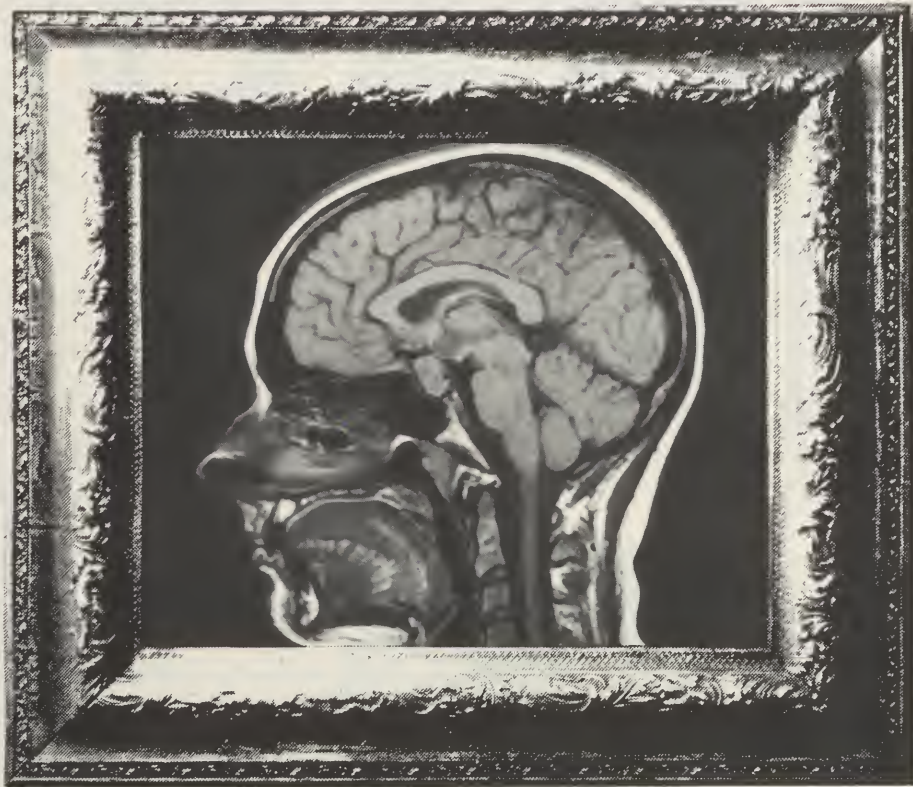
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Maryland Medical Journal

Premiere appearance of
CLINICOPATHOLOGIC
CONFERENCES
at Johns Hopkins
on page 418

MAY 1992

VOLUME 41 NO 5

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Betsy Newman

"Med Chi is a great organization," Says Dr. Yosunico. "Whatever I try to do during my year as president, I'm going to give one hundred percent. I'm a team player. That's my style."

Lyme disease in Maryland: 1987–1990 391

Clifford S. Mitchell, S.M., M.D., M.P.H.; Marianne Cloeren, M.D., M.P.H.; Ebenezer Israel, M.D., M.P.H.; Christina Lazar, M.D.; and Brian S. Schwartz, M.D., M.S.

We describe the epidemiology of Lyme disease in Maryland for 1987 to 1990 when the number of cases reported grew from 23 to 448 and the number of cases meeting the CDC case definition grew from 23 to 238, as well as discuss the implications of increased reporting and diagnosis of Lyme disease.

The clinical use of histamine-2 receptor antagonists 397

Robert J. Michocki, Pharm.D. and James P. Richardson, M.D.

Histamine-2 receptor antagonists have been available for fifteen years for the treatment of peptic ulcer disease and related disorders. While very safe, clinicians need to know correct dosing guidelines, drug interactions, and side effect profiles. Long-term therapy should be reserved for patients at high risk of recurrence.

Normal sexual development of children:

Physician roles in bridging gaps in parent-child communication 401

Steven H. Lipsius, M.D., M.P.H., F.A.P.A.

Physicians have opportunities to help a child have pride about his or her body, support the child's sexual self, and encourage shame-free limit setting. By supporting a parental coalition that is resilient and indivisible, physicians help children value their gender role and may influence the outcome of sexual orientation.

Journey of the Maryland International Health Task Force

to post-war Kuwait: May 19–27, 1991 407

The Kuwait 38

Thirty-eight physicians, nurses, hospital administrators, and support personnel—members of the Maryland Medical Task Force—journeyed to Kuwait in May 1991. The experience sensitized members of the Maryland delegation to the specific needs of post-war Kuwait in rebuilding its health care system.

Update on health status in Kuwait 412

James P.G. Flynn, M.D., M.P.H.

Medical History—James McHenry, M.D. of Fort McHenry in Baltimore Towne 413

Joseph M. Miller, M.D.

James McHenry, M.D., whose name is best known for the fort immortalized in the *Star Spangled Banner*, was one of the early members of Med Chi. In addition, he was secretary to George Washington; aide to Lafayette; member of the Maryland Senate, the General Assembly of Maryland, and US Congress; and signer of the Constitution.



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Jose Yosunico, M.D. stands before the flags of the 24 county component societies that comprise Med Chi. Dr. Yosunico has been a member of the Baltimore City Medical Society (BCMS) since 1957 and has participated at the executive level at BCMS and at Med Chi since the early 1980s. He will assume the office of Med Chi president during the House of Delegates meeting on May 2, 1992.

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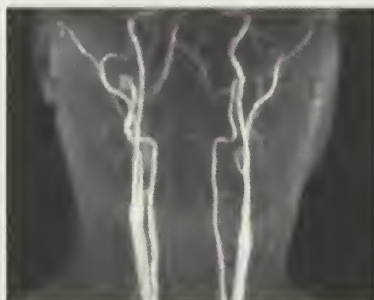
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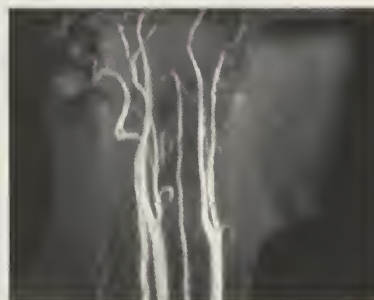
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Editorial

Professional courtesy: A bygone era

Is professional courtesy dead? For as long as anyone can remember, physicians have provided professional services, without charge, to other physicians and their immediate families. Indeed, physicians considered it to be a compliment that they had been chosen to care for their peers. ■

The Hippocratic oath says, ".... and I will keep this oath and stipulation: To reckon him who teach me this art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required; to regard his offspring as on the same footing with my own brothers" The American Medical Association Code of Ethics proposes that a physician "cheerfully and without recompense give his professional services to physicians or their dependents."¹ In spite of these moral and ethical historical statements, one suspects that professional courtesy has gone the way of the house call and black and white television. The system has gone over to the "robot physician" and computerized office management.

When I began practice almost fifty years ago, professional courtesy was a community standard from which one never considered deviating. Charging one's peers or immediate relatives was not done and was just cause for ostracism from the medical community. Occasionally, the clergy, nurses, dentists, pharmacists, and close associates were also granted professional courtesy. This was more of a policy in small towns than in urban areas. Most medical practice consultants agree that professional courtesy—not only to fellow physicians, but also to such people as pharmacists and hospital personnel—is an excellent practice builder.

Curiously, psychiatrists almost never gave complete professional courtesy on the grounds that there were only a limited number of hours in the day that could be productive, and that the therapy would be more effective if it were costly. I have never understood this reasoning since these grounds would

seem to apply to the care provided by all physicians.²

The times have changed. The erosion of the code of professional courtesy has come about by urbanization, computerization, and third party payers. The list of persons to whom professional courtesy was offered gradually condensed. The first to be deleted were the clergy and pharmacists; then the nurses and dentists were asked to pay a specific percentage of the full fee. Many older physicians, however, who were set in their ways and imbued with the honor and pride of the custom, continued their professional courtesy practices.

Nevertheless, changes were being made in the tradition, and younger physicians limited the practice to physicians, their spouses, and their dependent children. The art of medicine had been transformed into the business of medicine. Some physicians rationalized that they were giving away too much free time, that with rising office overhead and huge home mortgage payments, they could no longer afford the luxury of professional courtesy. Now, much more importance is attached to money and the material things that it can buy than in the old days.

A survey conducted recently by *Medical Economics* revealed that professional courtesy provided by the typical physician isn't likely to exceed 2 percent of the total value of his or her services in a given year.³ In return, isn't that small cost repaid by patient referrals from the person receiving the professional courtesy and by the receipt of professional courtesy care for the provider's spouse and children? In addition, there is the prestige and honor of having been selected by a fellow physician to provide medical care for his or her peers in the community.

It is possible, in certain specialized practices, that the value of free care might be a real financial burden. In such cases, a drastic cutback is called for. Most doctors are uncertain how much professional courtesy is costing and, if in doubt, should consider keeping dollar records on such patients for at least several months.

Nowadays, it is a common practice for physicians to have health insurance for their families. Most physicians will accept insurance payments for the professional courtesy treatment provided. This allows the recipient of the care to feel justified in taking up the physician's time and eliminates the chore of looking for a gift for the donor of the care. Years ago it was considered an insult to even offer insurance coverage for the care of a fellow physician or the physician's family. Times have changed, and most physicians now accept any insurance payment as full payment for the care provided.

Courtesy allowances should apply to the time provided by the physician only and not to items such as x-rays, expensive injections, and laboratory procedures. If insurance payments do not reimburse for these procedures, the recipient of the care should insist upon paying the dollar amount involved.

Many multiphysician centers have a separate billing office and a physician may not know how much money is being passed. The impersonal corporation knows nothing of professional courtesy; all it knows is the bottom line. The practice of medicine has become so impersonalized that beneath the surface, an adversarial relationship often exists between the doctor and the patient. This hardly lends itself to professional courtesy.

Physicians may pretend that they don't know what is going on in their own office and so erase themselves from the equation. This is a poor excuse and should be a source of embarrassment to a really dedicated physician.

Another factor in the reduction of professional courtesy is the third party payment system. It compensates a certain amount and then calculates what the patient should pay the physician. Weeks or even months after the visit, the business clerk, either through ignorance or feigned ignorance, bills the physician-patient for the balance. Business is business.

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3. Farber L, ed. Encyclopedia of Practice and Financial Management. Second Edition. Oradell NJ: Medical Economics Books. 1988; 206.

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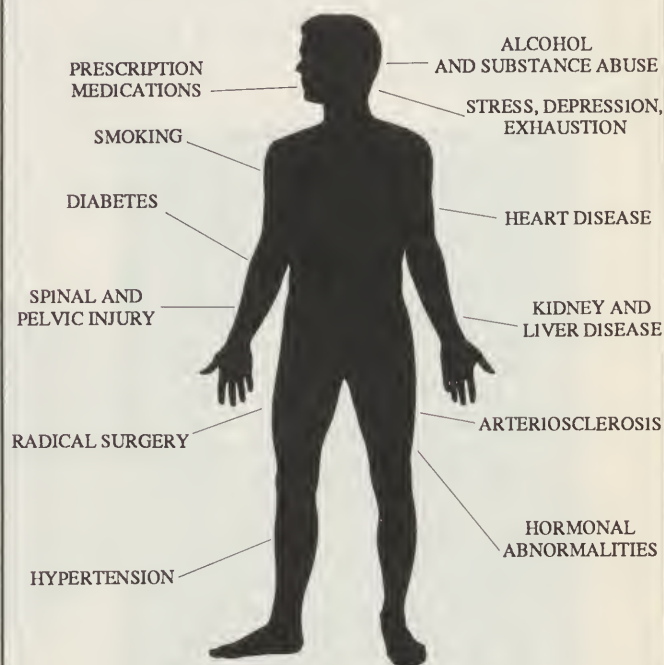
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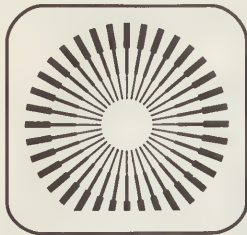
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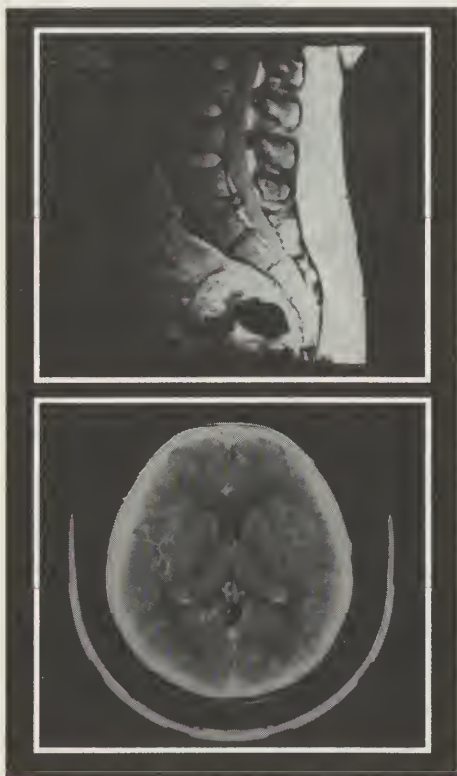


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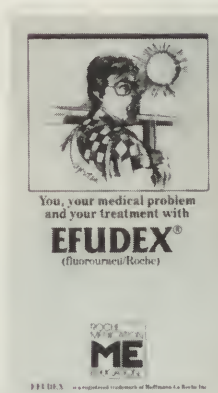
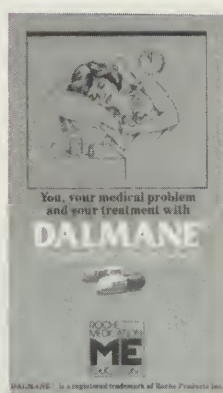
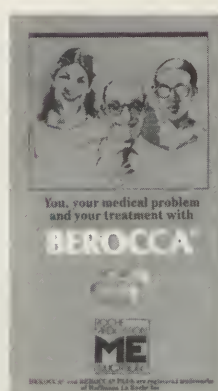


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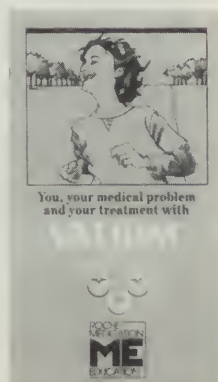
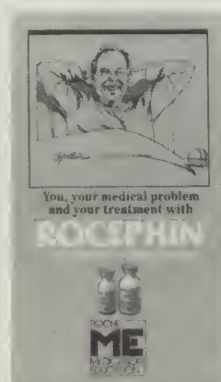
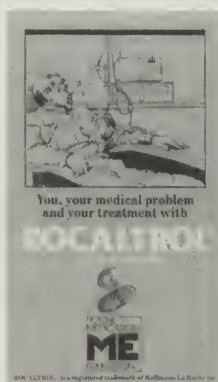
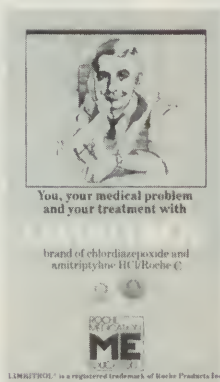
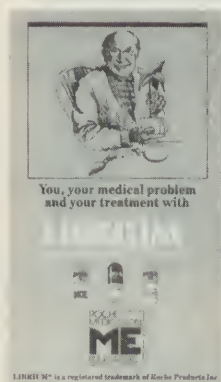


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The state of heads

Bart Gershen, M.D.

One of the unique signs of portal hypertension is the *caput medusae*, a cluster of dilated periumbilical venules. The name was obtained from its resemblance to Medusa, the mythologic Gorgon, whose body was covered with dense scales, whose head was covered with snakes, and whose gaze turned people to stone.

The word *caput* in Latin means 'head'. Presumably the coiled, twisted, and distended abdominal vessels reminded some romantic clinician of Medusa's serpentine tresses.

Of course *caput* has spawned several words which we use more commonly. **Capitation** is a method of compensation per head. Insurance companies employ that term frequently—but not often enough. The apparel men and boys wear for fun—a **cap**—also originates from *caput*. **Capital** punishment derives from a rather nasty method of exterminating the criminal—by **decapitation**. (**Capital** is also used to define the city that contains the head—although it's more often the seat—of our government.) The leader of a military force or of a large industry is often called a **captain**.

Wealth in the form of money or property is also referred to as **capital**, since it belongs to one person. In Middle English, the word evolved to **chattel**—referring to one's belongings or possessions. Thus the term **chattel mortgage**. In fact, a variant of chattel became **cattle** since they often represented a man's entire capital wealth. (How many **head of cattle**, therefore, becomes almost redundant.)

In publishing, arranging an index by headings was to **capitulate** them. Soon this word was employed to specify terms of surrender or capitulation. When a French knight was outfitted from head to foot it was known as *cap-a-pie* (*pie* from the Latin *pes* 'foot' which became the French *pié*.) *Cap-a-pie* soon came to mean 'in fine shape'. But when Americans heard the term, they understood it as 'apple-pie'. Thus the phrase, "everything's in apple pie order."

A bandage shaped like a cap and used to cover a head wound or the stump of an amputated limb is called a **capeline**. (The material from which a bandage is most often fashioned is **gauze**, named for the mid-east city from which it originated—Gaza.) The Latin for bandage was *fascia*—a

word also used to signify a sheet or bundle of fibers, as in **Buck's fascia** of the penis (named for Gurdon Buck, a nineteenth century American surgeon).

Ancient Roman magistrates were always preceded into the city by lictors, who heralded their arrival. This was accomplished by requiring the lictors to carry long poles onto which were mounted bundles of birch rods tied together with red bands. Thrust into the middle of those clusters was the protruding blade of an ax. These bundles of sticks were called *fascies* and represented the united authority of the Roman government.

In 1919, Benito Mussolini organized a group of revolutionaries and made use of this ancient Roman symbol of solidarity. He called his new party the Partito Nazionale Fascista—the fascist movement.

A cloak with a hood is called a **cape**. The term has evolved from *caput* through *cappa* to *capella* and finally to **cape**. (A projection of land into a body of water—or a headland—is also known as a **cape**.) In the third century A.D., a Frenchman named Martin left his home in Tours to join the Roman legions. One morning, at the gates to the city of Amiens, he saw a poor, frightened man trembling with cold. Martin ripped his cape in two and offered half to the beggar. The other half he wrapped about his own shoulders and rode off.

After his death, Martin was elevated to sainthood and the torn cape became an object of worship. It was preserved by the Frankish kings who took it with them into battle and sheltered it in a special tent. During peacetime, it was solemnly maintained in a dedicated room within their castle. The room became known as the cape room and was thus called the *capella*. The guardian of the cape came to be known as a *capellanus*. Slowly, as Latin evolved into French, the room became known as a *chapele* and its warden known as the *chapelain*. Worship services began to be held in this special place. We know it today as a chapel and its chaplain.

The church choir often practiced in this room. Since no organ was present, the choir sang without musical accompaniment. It was known as singing a *capella*—according to the chapel. ■

Our Pictures Are Worth A Thousand Words.

#Case 20

A 67 year old female with severe headaches, sinusitis and history of recent tooth extraction.

DIAGNOSIS: BRAIN ABSCESS right cerebral hemisphere.

Figure 1 demonstrates a 3 cm. hyperintense mass abutting the brain surface of the occipitoparietal lobes. A peripheral thin rim of hypointensity surrounds the lesion (arrows) and diffuse hyperintense signal extends through the adjacent white matter consistent with vasogenic edema. Figure 2 demonstrates a post Gadolinium enhanced T1 weighted scan. The central area of hypointensity corresponds with necrosis. The peripheral rim of contrast enhancement represents the abscess capsule. Double arrow demonstrates abnormal contrast enhancement of the leptomeninges.

The differential diagnosis of a ring enhancing lesion includes high grade astrocytoma, metastasis, infarction (bland or septic), and resolving hematoma. MRI can be extremely helpful in differentiating focal cerebritis from abscess. This is important as the former is treated medically and the latter is typically surgically drained and/or excised. Serial MRI scans also demonstrate decrease in edema, mass effect and degree of enhancement during follow-up.

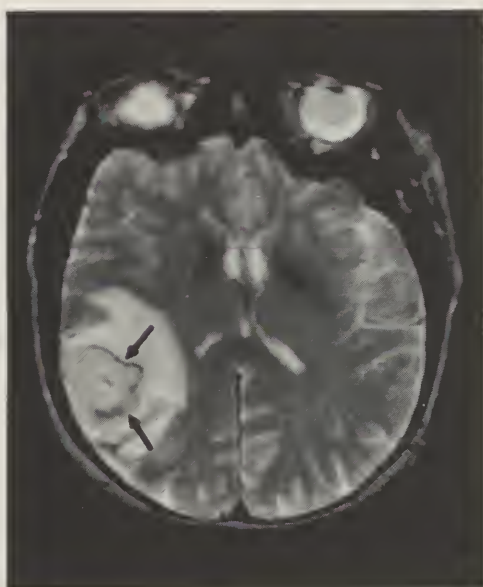


FIGURE 1

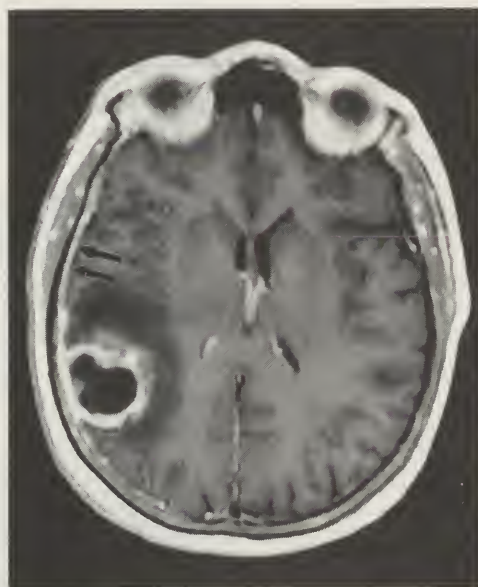


FIGURE 2

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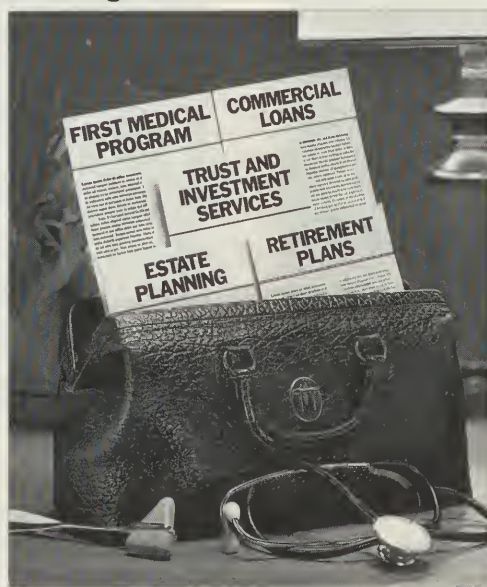
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Executive Director's Newsletter

May 1992

Jose M. Yosuico, M.D.,
New Med Chi President

On May 2, 1992, Jose M. Yosuico, M.D. will become Med Chi's 132nd president. As president for 1992-1993, Dr. Yosuico hopes to increase Med Chi's membership, and is calling for increased teamwork during these challenging times. For more on Dr. Yosuico, see his article on page 385 of this *MMJ*.

Component Society
Presidents

For the second consecutive year, the *MMJ* is publishing biographies of Med Chi's component medical society presidents. We hope you take time to look at pages 427-433 of this *MMJ* to read about these important leaders of organized medicine.

HCFA Correcting
Payments

The American Medical Association has reported that the Health Care Financing Administration (HCFA) has instructed its carriers to establish adjusted historical payment bases (AHPBs) for approximately 40 CPT codes that were new in 1991 or 1992 because HCFA discovered that the transition rules were incorrectly applied when the 1992 payment amounts were calculated. Because the AHPBs were set at zero, these codes went immediately to the full RBRVS payment schedule with no transition. HCFA is now providing "crosswalks" to old codes to be used by carriers in establishing AHPBs. This situation will probably result in new 1992 payment amounts for these procedures.

Furthermore, the relative value units for approximately 150 technical component codes and the related global code will be changed as a result of a new methodology to calculate the technical components. Carriers should be notifying providers of the new payment amounts and charge limits by April 30, 1992.

NOTE: Carriers have been instructed to **reopen** any claims for services submitted after December 31, 1991 that are brought to their attention for correction. Carriers do not have to make up for any underpayments to physicians. Therefore, physicians should carefully review the new payment amounts to see if they are due any additional payment.

Thank You to "Doctor of
the Day" Volunteers

Med Chi thanks all 46 physicians who participated in the 1992 "Doctor of the Day" program in Annapolis. Volunteer physicians served during the legislative session and treated a variety of ills. Med Chi appreciates the help of all the physicians who helped make this year's program a great success.

1992 Med Chi
Semiannual Meeting

Med Chi's Semiannual Meeting will be held Friday, Saturday, and Sunday, September 18, 19, and 20 at the Princess Royale Hotel in Ocean City, Maryland. Watch the June issue of the *Maryland Medical Journal* for a Call for Papers for this meeting.

G.W.U. Intern

Ms. Rose Mahoney, a graduate of George Washington University's health care administration program, recently joined Med Chi as part of her residency under the preceptorship of Angelo J. Troisi, F.A.C.H.E., Executive Director.

Public Health Programs

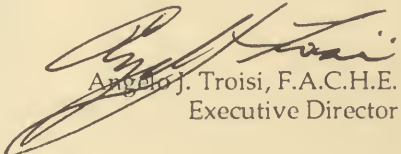
The George Washington University is offering a variety of summer health policy programs for health care providers. From June 17-19, 1992, the university will offer three concurrent conferences:

- Bioethics and Health Policy Conference
- Environmental/Occupational Health Symposium
- International Health and Development Forum

On June 22-26, the university will sponsor a summer health policy institute on Federal Health Policy: A Detailed View of the Issues and the Process. For more information about any of these programs, contact Martha Cosgrove, Senior Education Specialist for George Washington University, at 202-994-4536.

New CPT Evaluation and Management Codes for 1992

In a continuing effort to keep you apprised of the latest developments in CPT evaluation and management codes for 1992, Med Chi is pleased to provide you with the final section of this series of commonly asked questions. The listing, which was prepared by the Health Care Financing Administration, follows this newsletter.



Angelo J. Troisi, F.A.C.H.E.
Executive Director

New CPT Evaluation and Management Codes for 1992 Questions and Answers

(These questions are the final part of a listing of commonly asked questions about CPT codes. To review the first two lists of questions see the March and April editions of Executive Director's Newsletter)

21. What are the payment implications for modifier "-78" and modifier "-79"?

Modifier "-78" — Return to the operating room for a related procedure during a postoperative period. The physician may need to indicate that a procedure was performed during the postoperative period of another procedure. When this subsequent procedure is related to the first procedure and requires the use of the operating room, this circumstance may be reported by adding the modifier "-78" to the related procedure.

If this modifier is reported with an unlisted procedure code, the Medicare payment is based on up to 50 percent of the intraoperative value of the original procedure. If this modifier is reported with a specific procedure code that describes the services performed, payment is based on the intraoperative portion of the service.

Modifier "-79" — Unrelated procedure by the same physician during a postoperative period. The physician may need to indicate that the performance of a procedure

or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using the modifier "-79."

If this modifier is reported, payment may be made at the full value of the unrelated procedure.

22. Will Medicare pay for a visit and a procedure on the same day if reported by the same physician for the same patient?

Medicare will not pay separately for a visit on the same day as a minor surgery or endoscopic procedure unless other significant, separately identifiable services are performed in addition to the procedure. The payment amount for the procedure covers such pre- and post-service work as recordkeeping, counseling and prescribing recovery therapy. However, if other significant evaluation and management services are performed on the same day, the physician may bill for the visit with modifier "-25." In determining the level of visit to bill with the modifier,

physicians should consider only the content and time associated with the separate evaluation and management service, not the content or time of the procedure.

Visits that are related to a major surgery are not paid for separately if reported by the same physician on the same day as the surgery. However, the initial evaluation or consultation by the surgeon will be paid for separately even if reported on the same day.

23. Will Medicare pay for an evaluation and management service and a diagnostic procedure for the same patient on the same day?

If the diagnostic procedure is considered a surgical procedure or is an endoscopy, the rules on payment for evaluation and management services described in the response to question number 23 apply. Medicare will pay for medically necessary evaluation and management services reported on the same day as other diagnostic procedures such as laboratory tests or radiological examinations.

24. Can code 99211 be reported if a nurse in the physician's office provides instruction on self-administering insulin?

The definition of code 99211 is as follows: Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician.

Yes. If a limited service is performed by a physician's employee, this code may be used to report services that may not require personal performance by a physician. However, this code should not be reported in addition to other evaluation and management services performed by the physician on the same day.

25. In what situations will electrocardiogram (EKG) interpretations still be payable under the Medicare program?

Carriers should assume that EKG interpretations are always "performed or ordered in conjunction with a visit or consultation." This assumption is valid even if no visit or consultation is reported. For example, an orthopedist is called in on an emergency basis to perform hip surgery, examines the patient and orders an EKG prior to surgery to rule out a heart problem. Payment cannot be made to a cardiologist for the EKG interpretation because it was ordered in conjunction with the orthopedist's visit or consultation. This is true even if the orthopedic surgeon chooses not to report the patient encounter.

26. In the Medicare program, nurse practitioners and physician assistants are paid 80 percent of the lower of the reasonable charge or the applicable percentage of the fee schedule. How will this rule be applied to the visit services since there are no customary or prevailing charges for these services in 1992?

For 1992, carriers should base Medicare payments on the lower of the actual charge or the applicable percentage of the fee schedule. Since the visit code definitions changed, carriers did not do a reasonable charge update

for 1992. HCFA is not asking carriers to "gap fill" reasonable charges for this purpose. For 1993, customary and prevailing charges can be developed from January 1, 1992 through June 30, 1992 data. (The normal reasonable charge update period would be July 1991 through June 1992, but since the new visit codes won't go into effect until January 1, 1993, carriers will use six months of data for the 1993 reasonable charge update).

27. If modifier "-21" is used by a non-participating physician, how is the Medicare limiting charge applied?

Modifier "-21" is used for unusual evaluation and management services. This modifier has no effect on payment; therefore, the limiting charge is the same for the code with no modifier. At this time, HCFA plans to review these claims on a postpayment basis in order to collect information on the use of this modifier.

28. Now that modifier "-75" has been deleted from the CPT book, how will Medicare carriers identify concurrent care? How will concurrent care be paid?

Concurrent care will be recognized by carrier claims processing systems. Systems will identify instances where two physicians submit claims for visits to a patient on the same day. If the care of two physicians is medically necessary, Medicare will pay for the services of both physicians. Generally, if the physicians are of different specialties and are caring for different conditions, the services will be considered medically necessary.

29. If Medicare is the secondary payer and the primary insurer uses the old visit codes, will Medicare then accept the old visit codes?

For the month of January 1992, Medicare will accept the old visit codes whether it is the primary or secondary payer. After January 31, 1992, carriers will suspend the claim and request that the physician provide the new visit codes. Carrier will request the new codes even when the primary payer made payment under the old visit code. Secondary payment will be based on the difference between what the primary payer paid and the new code that the physician provides.

30. In a nursing facility, will Medicare pay for both a psychotherapy service and a nursing facility visit on the same day for the same patient? May a psychiatrist report either a CPT psychiatric visit code or a generic evaluation and management code? If yes, will Medicare pay for both services on the same day?

Depending on the services provided, Medicare will pay for the appropriate service -- either the psychiatric visit or the generic evaluation and management (E/M) service. Medicare will not pay for both services on the same day for the same patient.

31. Will Medicare pay ophthalmologists for either the CPT generic visit codes or the CPT ophthalmology codes (92002-92014)?

Yes. Ophthalmologists may use either set of codes.

32. Now that the 1992 CPT book has a new ophthalmological code for refraction (code 92015), should the AP modifier be reported if a refraction is not done?

No. Physicians should charge separately for the visit and refraction and not use the AP modifier. Medicare carriers will assume this is the way physicians are reporting to Medicare.

33. How do independent physical therapists and physicians report physical therapy to Medicare? Do they report CPT therapy codes, or CPT general visit codes, or the HCPCS codes M0005-M0008? When they choose to use the CPT codes instead of the HCPCS codes, will Medicare pay for a visit and the modality/treatments if they are provided on the same day?

Independent physical therapists and/or physicians may bill for physical therapy to Medicare using either the HCPCS M codes (visit with modalities and/or treatments) or using the CPT therapy codes. They may not report both HCPCS M codes and CPT therapy codes for services provided on the same day.

Independent physical therapists cannot report the general CPT visit codes to Medicare.

Physicians may report general visit codes for services provided the same day as CPT therapy codes only if they provide separately identifiable services that meet the definition of a visit.

There will be no difference in Medicare payment amounts made to physicians and therapists when they bill the same code.

34. For a hospital inpatient stay that begins in December 1991 and ends in January 1992, which inpatient hospital codes should be used?

For the services before January 1, 1992, the old visit codes should be used. For the hospital visits on or after January 1, 1992, the new visit codes should be used.

35. If the new visit codes are used for services PRIOR to January 1, 1992, will Medicare pay for them?

No. The Medicare fee schedule and the new visit codes are effective for services on or after January 1, 1992.

36. In a hospital inpatient situation involving one physician covering for another, if physician A sees the patient in the morning and physician B, who is covering for A, sees the same patient in the evening, will Medicare pay physician B for the second visit?

No. The hospital visit descriptors include the phrase "per day" meaning care for the day. If physician B covers for physician A, Medicare will not pay for the services of physician B.

37. When is a patient a "new patient"? How does the 3-year requirement for a new patient apply to members of groups?

The 1992 CPT defines a new patient as one who has

not received any professional services from the physician within the past 3 years.

For Medicare payment purposes, HCFA interprets the term "physician" to include all physicians practicing in the same group and billing with the same billing number regardless of specialty. If any member of a group has seen the patient and billed a visit or consultation within 3 years, the patient is considered "established." However, if only services other than visits or consultations were received within 3 years (e.g., anesthesiology, pathology), the patient is considered "new."

38. Will Medicare pay for a consultation if one physician in a group practice requests a consultation from another physician in the same practice?

Yes. As long as the Medicare requirements for a consultation are met, Medicare will pay for a consultation from another physician in the same group. The consultation must be requested by the attending physician; the consultant must obtain a history and examine the patient; and a written report of findings must be furnished to the attending physician.

39. Will emergency department physicians (who have limited knowledge of a patient's medical history) be required to use the new modifiers for services within the global surgery period in order to be paid?

The new modifiers are:

Modifier "-79"—unrelated procedure by the same physician during a postoperative period;

Modifier "-24"—unrelated evaluation and management service by the same physician during a postoperative period.

The emergency department physician would not use a modifier unless the emergency department physician happened to be the operating surgeon. These modifiers are intended for use by the operating surgeon only.

40. If Dr. Smith transfers a patient from hospital A to hospital B for treatment, will Medicare pay Dr. Smith for both the hospital discharge day management services at hospital A and hospital admission at hospital B?

Yes. Medicare will pay for the hospital discharge day management services at hospital A and the hospital admission services at hospital B. Generally, Dr. Smith's hospital admission services at hospital B would be at a low level because much of the work normally associated with the admission had already been performed by him in hospital A.

41. For new physicians, are the emergency department evaluation and management codes (99281-99285) considered primary care codes and therefore not subject to new physician reduction rules?

Yes. The emergency department codes are considered primary care codes and these codes are not subject to the new physician reduction rules. Other services performed in the emergency department are subject to the reduction.

BOOK REVIEW BOOK REVIEW BOOK

The 14 Day Stress Cure. Mort Orman, M.D.
Houston: Breakthru Publishers. 1991. 323 pages.
\$22.95 hardcover. \$13.95 softcover.

Discussions of methods to deal with stress have been appearing for over thirty years. In the new book by internist Mort Orman, he has described a fascinating new approach to life and stress. He has not taken or modified the prior approaches to stress management techniques but has created what he calls the ultimate approach.

The book begins with Dr. Orman describing why prior methods have not been appropriate or effective long-term and his purpose in writing the book. He believes that with his ultimate approach you can "improve your health, enhance the quality of interpersonal relationships, increase your productivity, raise your confidence and self-esteem and become more successful in other areas of your life." He then provides some validation of this approach by relating how his own life improved.

The book is organized into fourteen chapters, each chapter representing one day in the fourteen-day cure. Each chapter begins with a discussion of a particular aspect of stress or technique in the approach and at the end of each chapter are daily exercises to help reinforce the ideas presented.

The premise of the book is presented in chapter 1 using biolinguistics, a viewpoint that focuses on the role of language in human stress. Dr. Orman described how "stress is just a word." With this concept, stress itself does not exist, there is no good or healthy stress, stress is not caused by external forces, and there is a better way to deal with stress than "managing it."

In chapters 4-13, the book informs you of the step-by-step approach for coping with stress, provides further explanation of each step, and provides examples of how any stress can be handled by this approach. In the final chapter, ways to overcome common obstacles to fully using this approach are discussed.

This book provides a very healthy and positive approach to life and, therefore, stress. Individuals who are motivated and psychologically stable might well benefit from this approach. It is not intended to replace diets, exercising, medications, or psychotherapy. This is clearly stated by the publishers at the beginning of the book.

The problem with this book and all books about ways to deal with life, is that they are based primarily on the author's own life experiences and anecdotal reports of success. And while these may be valid observations, we have no data that this approach really alters peoples lives and accomplishes the goals set forth initially. While randomized trials would be difficult; the anecdotal successes may represent an individual who was ready to approach life differently regardless of the techniques used.

The book is an interesting, reasonable, and healthy approach to stress. Some physicians and patients could appreciate and benefit from reading it. It would be most interesting if objective data could be collected to validate the use of this approach.

HERBERT L. MUNCIE, JR., M.D.
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Annual Meetings

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Featuring: Thomas R. Reardon
M.D. AMA Trustee

Presidential Banquet : May 2, 1992
Honoring J. David Nagel, M.D.

Thursday, Friday and Saturday
April 30, May 1, and
May 2, 1992

Meeting Overview

Thursday, April 30, 1992

8:00 a.m. – 5:00 p.m. – Registration
8:30 a.m. – Council Meeting
9:30 a.m. – House of Delegates Meeting/General
Membership Meeting featuring:
Special Guest Speaker
Ron Shapiro, Esq.
9:30 a.m. – Spouse Program
11:00 a.m. – 4:00 p.m. – Auxiliary 43rd Annual Meeting
11:30 – Scientific Session
12:00 noon – 12:30 p.m. – Break – *Visit the Exhibits* –
12:30 p.m. – 1:30 p.m. – Lunch on your own
1:30 p.m. – 2:30 p.m. – Plenary Session
"Health Care Reform"
AMA Trustee Thomas R. Reardon, M.D.
2:30 p.m. – 3:00 p.m. – Break – *Visit the Exhibits* –
Exhibitor Sweepstakes Drawing
3:00 p.m. – 6:00 p.m. – Scientific Sessions
4:15 p.m. – Workshop
*"Avoiding Excess Retirement and Estate Taxes:
Strategies for the 90s"*
Med Chi Agency
6:00 p.m. – 9:30 p.m. – Harbor Cruise aboard the
Lady Baltimore
(Advance registration required – space is limited)

Friday, May 1, 1992

7:00 a.m. – Prayer Breakfast
8:00 a.m. – 5:00 p.m. – Registration

8:30 a.m. – Workshop

"Accreditation for Continuing Medical Education"

10:30 a.m. – Break – *Visit the Exhibits* –

Exhibitor Sweepstakes Drawing

12:00 noon – Auxiliary Meeting and Auction

12:30 p.m. – 1:30 p.m. – Lunch on your own

1:30 p.m. – Mini-Symposium

"Physician Office Labs: Master or Slave?"

4:00 p.m. – Workshop

"Computers in the Medical Office"

7:35 p.m. – Baltimore Orioles vs. Seattle Mariners

at the new Oriole Park at Camden Yards

(Reservations required – space is limited)

Saturday, May 2, 1992

8:00 a.m. – 12:00 noon – Registration

8:30 a.m. – Mini-Symposium

"Ethics of Dying"

8:30 a.m. – 1:00 p.m. – Scientific Sessions

10:30 a.m. – 11:00 a.m. – Break – *Visit the Exhibits* –

Exhibitor Sweepstakes Drawing

11:00 a.m. – Spouse Program

12:30 p.m. – 1:30 p.m. – Lunch on your own

2:00 p.m. – House of Delegates Meeting

3:00 p.m. – Council Meeting

7:00 p.m. – Presidential Banquet

Honoring Med Chi President J. David Nagel, M.D.

(Reservations required – black tie optional)

For registration information call Med Chi
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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

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Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

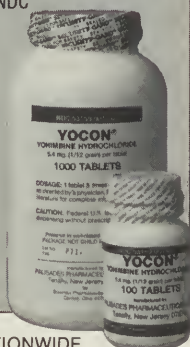
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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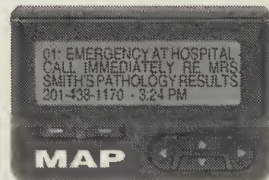
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Jose M. Yosuico, M.D.

1992–1993 Med Chi President

Betsy Newman

Ms. Newman is director of public relations, Medical and Chirurgical Faculty of Maryland.

"Med Chi is a great organization," says Dr. Yosuico. "Whatever I try to do during my year as president, I'm going to give one hundred percent. I'm a team player. That's my style."

Walking through the halls of Church Hospital with Jose M. Yosuico, M.D. is like strolling down Main Street, USA with a very popular mayor. He knows everyone and everyone knows him. Amidst all the smiles, waves, and "how are you's," it's clear why Dr. Yosuico has been affiliated with Church Home and Hospital for over thirty-five years—he likes the people. As president of Med Chi for 1992–1993, Dr. Yosuico hopes to use his friendly, personal style to embark on a new campaign—a campaign to encourage more physicians to join organized medicine and become part of the team.

Membership

"Increasing membership will be one of my main priorities as Med Chi president," says Dr. Yosuico. As chairperson of the Baltimore City Medical Society's (BCMS) membership committee in 1991, Dr. Yosuico succeeded in increasing the membership by seventy-six members. His method was simple—he asked every member physician in Baltimore City to get one nonmember to join. To help with this endeavor, he contacted member physicians in every hospital in Baltimore City and asked them to serve as recruitment leaders for their hospital. Dr. Yosuico would often meet personally with nonmember physicians interested in joining the society. As a result of his outstanding efforts, Dr. Yosuico has received the BCMS "Recruiter of the Year Award" for 1988, 1989, and 1990. As the current chairperson of the BCMS membership committee, Dr. Yosuico still keeps in contact with his hospital leaders and often talks one-on-one with nonmember physicians about the benefits of organized medicine.

During his term as Med Chi president, Dr. Yosuico intends to modify the membership recruitment model he used in Baltimore. Instead of hospital leaders, however, Dr. Yosuico will rely on Med Chi's twenty-six component societies to be the leaders in increasing membership.

"Component societies are Med Chi's backbone," says Dr. Yosuico. "Med Chi can assist the component societies in increasing their membership, but it is the component societies that really attract new members."



Dr. Yosiuco confers with Med Chi Executive Director Angelo J. Troisi, F.A.C.H.E.

Dr. Yosiuco hopes component societies will adopt his "member-get-a-member" philosophy and plans to evaluate ways that Med Chi can aid its component societies in their membership efforts. For example, he was instrumental in getting a pilot project off the ground whereby component societies would keep fifty percent of a new member's first year dues in order to offset the costs of membership recruitment.

Dr. Yosiuco believes one way Med Chi can help component societies gain and keep new members is through member services. "We have to keep physicians informed of our accomplishments. We've got to remind them of what we've done for them in the past and what we're doing for them today."

Med Chi in Annapolis

"Med Chi is the spokesperson for Maryland physicians," explains Dr. Yosiuco. "We need to tell physicians about what we do for them in Annapolis." Dr. Yosiuco describes how Med Chi has helped to defeat measures that would initiate mandated Medicare assignment and triplicate prescriptions. Med Chi has also helped initiate tort reform and has supported legislation that benefits the public health, such as laws that restrict smoking in public places. During the 1992 session of the Maryland General Assembly, Med Chi represented the voice of Maryland physicians on a myriad of issues ranging from acupuncture to x-ray technologists. Legislation dealing with AIDS (acquired immunodeficiency syndrome) was especially prevalent during the 1992 session, with Med Chi representatives testifying on over twenty bills dealing with different aspects of AIDS and HIV (human immunodeficiency virus). Several bills were introduced that would have required mandatory HIV testing for health care workers. "There is no scientific evidence to support the cost of mandatory HIV testing for physicians," says Dr. Yosiuco. "[To date,] there is no known case of a physician who has passed HIV to a patient." Dr. Yosiuco adds that mandatory testing

of doctors would be prohibitive. "We should spend our money to educate and treat rather than test."

The health care system and Health Access America

Another major issue that greatly concerns Dr. Yosiuco is the changing face of our health care system. During the 1992 Maryland General Assembly, several health care reform proposals were introduced. One bill would have implemented Universal Health Insurance, a single payer health care system that would replace Maryland's current health care system with one similar to the Canadian health care system that is financed and run by the government. Dr. Yosiuco, who does not favor extensive government regulation of medicine, is opposed to attempts to create a Canadian system of health care in this country. "I hope we don't have national

health insurance," says Dr. Yosiuco, who believes health care should be a cooperative combination of public and private resources.

"The AMA's [American Medical Association] Health Access America is a much better plan than Universal Health Insurance," says Dr. Yosiuco. Health Access America, which was developed in response to calls for a national health plan, attempts to address the weaknesses of our current medical system while preserving its strengths. Some other fundamental principles of Health Access America are

- providing affordable and appropriate health care coverage for all Americans, regardless of income;
- assuring continued access to affordable health care for the elderly;
- delivering health care at appropriate costs;
- allowing patients the freedom to choose their health care provider and the manner in which their health care benefits are delivered; and
- maintaining the highest ethical standards of medical care.

Recently, Med Chi received a grant from the AMA with the principal goal of educating Maryland physicians, the public, the media, and legislators about Health Access America as an alternative to any national health insurance proposal.

Health care costs

"It is true that the cost of health care keeps going up," says Dr. Yosiuco. "But it is also going up in other countries where you have to wait for health care...and the quality of care isn't as good." He maintains that physicians are the scapegoats for the debate surrounding our nation's health system. "They say that 11 percent of the GNP (gross national product) is health care. Health care is comprised of hospitals, pharmaceutical companies, nursing homes...all of which cost huge amounts of money when compared with the cost of a physician's care."

"The cost of health care has gone out of control, but it's not because of the physician alone. The doctor is one small factor. It is society," says Dr. Yosunico. He refers to a recent study in *JAMA* (September 18, 1991) that estimates that cocaine-addicted babies cost hospitals in excess of \$500 million dollars annually. "We have to take care of babies who are born addicted to drugs," he says. "Doctors don't deny people care. The job of the doctor is to take care of the patient...to make sure patients have a high quality of life...to make every patient physically and emotionally well."

Dr. Yosunico believes one reason physicians are accused of contributing to increasing health care costs is because of new and better technologies. He explains that the price for these new technologies is often very expensive. "When a doctor orders a test it is because the patient needs that particular test. Too often, the doctor is blamed because the needed test costs a lot of money. Tests and procedures are necessary in order for a physician to make the proper diagnosis. Doctors have to prescribe the right test in order to give the right medicine at the right time."

"But we shouldn't order tests because we want to avoid a liability suit," adds Dr. Yosunico. He maintains that physicians should follow strict ethical standards. Defensive medicine practices contribute to high medical costs, believes Dr. Yosunico. "Doctors should take care of their patients needs and not worry about being sued."

Professionalism

"Professionalism should be foremost for all physicians," he says and explains that professionalism should apply to all aspects of medical practice. He also states that physicians should be required to disclose any of their financial interests in a medical facility to patients. "Doctors should give patients the option to choose where they want to have their tests and procedures done. That's the ethical part of medicine...without it, medicine would be just like any other business."

The future of medicine

Whatever changes are imposed on our current medical system in the coming years, Dr. Yosunico insists that physicians need to be an integral part of the decision-making process. "Quality of care must not be compromised when cutting costs," he says.

Dr. Yosunico hopes Marylanders will accept the major components of the Health Access America plan. "There are more than 30 million people in this country who are not covered by health insurance," says Dr. Yosunico. "We need to do something about it. I just hope this country doesn't resort to national health insurance." Dr. Yosunico hopes physicians will educate their patients about the drawbacks of a universal or government-run health care system.

The future of Med Chi

Increased communication with members is essential to keeping members informed about critical issues surrounding the future of our health care system, maintains Dr. Yosunico. In addition to his strategy for the membership, he plans to continue holding regional conferences around the state during the next year. Initiated in 1989 by Past President Michael R. Dobridge, M.D., the regional conferences were created to help update physicians living in the southern, western, and eastern regions of Maryland about important Med Chi issues. Regional meetings also enable Med Chi's president to address



"Med Chi has an excellent staff," says Dr. Yosunico, seated here with Med Chi Deputy Executive Director Carmine Valente, Ph.D. (l) and Med Chi Director of Finance Joseph J. Harrison (r).

local concerns. "Med Chi is constantly searching for new ways to help its members," says Dr. Yosunico.

"I know that more and more physicians will see the advantages of belonging to Med Chi," he adds, as he expresses his hope that he can encourage younger physicians to join Med Chi. "We need younger physicians to be involved at the leadership level," he says. "The sooner they get involved, the more active they will become and be able to participate at the leadership level."

"Med Chi also has an excellent staff," says Dr. Yosunico. "Most physicians have no idea how much staff actually do for the faculty's members. People like Angelo Troisi, Joe Harrison, Carmine Valente, Rose Matriccioni, and the rest of the staff really do a great job. As physician members, we have to do our best to retain all the good people who do so much for Med Chi."

"Med Chi is a great organization," says Dr. Yosunico.

"Whatever I try to do during my year as president, I'm going to give one hundred percent. I'm a team player. That's my style." ■

Jose M. Yosuico, M.D.

Jose M. Yosuico, M.D. still makes house calls. He has made house calls for over thirty-five years and vows that he will continue to make house calls for all his patients who are too ill or too old to make the trip to his Church Hospital office. Dr. Yosuico adds that many of the people he visits have been his patients for more than thirty years.

"I didn't always want to be a doctor," admits Dr. Yosuico. "I wanted to be a priest." Dr. Yosuico grew up attending a Catholic school in Manila, the capital of the Philippine Islands. He had a great admiration for the priesthood. His plans changed, however, during the Japanese invasion when he had an appendectomy with only local anesthesia. He was 14 years old. "I stayed in the hospital for more than a month," he says. "I saw doctors every day. I saw how the patients felt about their doctors and I said to myself, 'That's what I want to be.'"

In 1953, he graduated from the University of the Philippines College of Medicine in Manila and was accepted into a postgraduate training program at South Baltimore General Hospital. After completing a rotating internship there in 1954, Dr. Yosuico fulfilled his residency requirements in internal medicine at Church Home and Hospital from 1954 to 1957. "I chose South Baltimore General because it sounded like Philippine General," he admits. "I went to Church Hospital because I eventually wanted to go to Johns Hopkins."

But Dr. Yosuico never went to Hopkins. After finishing his year as chief resident at Church, he went into private practice in Laurel, but still sent his patients to Church. In 1957, he entered into private practice at Church and has never left. "I love this hospital," he confesses. Although Dr. Yosuico still holds privileges at Harbor Hospital Center (formerly South Baltimore General), he sees all of his patients at Church.

During his more than thirty-five-year affiliation with Church, Dr. Yosuico has been involved in almost every major committee of the hospital. He served as the hospital's chief of staff from 1981 to 1985. During that period he also served as chairperson of the Medical Execu-



Dr. Yosuico's family at the wedding of his daughter Lisa. From left to right—James Stahl, Theresa Stahl, Jennifer Sellner, John Sellner, Alexandra Sellner, Virginia Sellner, Jose M. Yosuico, M.D., Lisa Love, Andrew Love, Dorothy Yosuico, Joshua Yosuico, Michelle Yosuico, Megan Yosuico, Raymand Yosuico, and Mary Pat Yosuico.

tive Committee and was a member of the board of directors and the board of trustees. From 1985 to 1991, he served as chief of the Department of Emergency and Community Medicine. At present, he is on the board of the Church Home and Hospital Health Centers, and is chairperson of the Medical Advisory Committee and the Utilization Review Committee.

In addition to his extensive involvement with Church Hospital, Dr. Yosuico was physician-in-charge at the Maryland House of Correction from 1958 to 1976. He also served as an associate in medicine at the Maryland School of Medicine from 1962 to 1976.

Dr. Yosuico has long been an active participant in organized medicine. A member of the American Medical Association and the American Medical Association Political Action Committee since 1957, Dr.

Yosuico became active on the state level in 1978 when he served as chairperson for Med Chi's Physician/Patient



Dr. Yosuico's two youngest grandchildren, Sarah and Benjamin Stahl.

Relations Committee. In 1980, he was elected to the Med Chi House of Delegates. Four years later, he was elected as treasurer for the faculty and subsequently became chairperson of Med Chi's Finance Committee.

In 1981, Dr. Yosuiico became a member of the Board of Directors to the Baltimore City Medical Society (BCMS). Following his appointment to the Baltimore City Political Action Committee Board of Directors, Dr. Yosuiico was elected vice president of BCMS. He became president of BCMS in 1987.

Before he was chosen as president-elect of Med Chi in 1991, Dr. Yosuiico served as a member of the board of directors for the Baltimore City Medical Foundation; the Medical Service Corporation for BCMS; the Center for Health Education, Inc.; and Comprehensive Health Associates, P.A. Dr. Yosuiico will assume the office of Med Chi president during the House of Delegates meeting on May 2, 1992.

Dr. Yosuiico has received numerous awards in recognition of his many activities. He received a governor's citation for his work as commissioner for the Governor's Commission on Black and Minority Health from 1986 to 1988. He received a second governor's citation in 1990. In addition to being the recipient of the Distinguished Alumnus Award from the University of the Philippines Medical Alumni Association of America, Baltimore Chapter, he holds several resolutions and certificates of appreciation.

Outside of his medical activities, Dr. Yosuiico is a founding member of several Filipino societies including the Filipino Society of Baltimore-Katipunan, the Association of Philippine Physicians of Maryland, and the University of the Philippines Medical Alumni Association of America, Baltimore Chapter. He is a member of the Association of Philippine Physicians of America, the Maryland Classified Employees Association, the National Rifle Association, the Jessup Rod and Gun Club, and the Optimist Club of Laurel, Maryland. Dr. Yosuiico is an avid gun collector and outdoorsman.

Dr. Yosuiico currently lives in Ellicott City with his wife, Dorothy. They have five children—Virginia, Raymond, Mary Pat, Theresa, and Lisa; and six grandchildren—Jennifer, Alexandra, Megan, Joshua, Sarah, and Benjamin. ■



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Lyme disease in Maryland: 1987–1990

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We describe the epidemiology of Lyme disease in Maryland for 1987 to 1990 when the number of cases reported grew from 23 to 448 and the number of cases meeting the CDC case definition grew from 23 to 238, as well as discuss the implications of increased reporting and diagnosis of Lyme disease.

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Lyme disease has become an increasingly important public health threat in the United States since it was first reported in this country in 1975 in Lyme, Connecticut. It is caused by a spirochete, *Borrelia burgdorferi*, and transmitted by infected ticks, most commonly of the species *Ixodes dammini*.¹ The disease usually begins with a spreading annular rash, erythema migrans (EM), that starts at the site of the bite and usually exhibits central clearing; the rash may occur from a few days to a few weeks after the bite. Flu-like symptoms including myalgia, headaches, and fever are often present at this stage. If the patient is treated with appropriate antibiotic therapy early in the disease, the patient is usually cured. If early symptoms do not occur or are unrecognized, late complications may occur from weeks to months after the bite; these complications include polyarthrititis, damage to the cardiac conduction system, and neurologic deficits. The late complications are variably responsive to antibiotic therapy and may result in permanent deficits; however, the majority of patients can be cured at all stages of the disease.²

Prior to 1989, Lyme disease was not reportable in Maryland. From 1984 to 1986, the number of cases reported in Maryland was relatively small: 10 in 1984, 20 in 1985, and 15 in 1986.³ In this report, we describe the epidemiology of Lyme disease in Maryland from 1987 to 1990.

Methods

All reports of Lyme disease reported from January 1, 1987 to December 31, 1990 by physicians, hospitals, and out-of-state laboratories to the Maryland Department of Health and Mental Hygiene (DHMH) were investigated. The number of Lyme serologic tests performed by the state

health department laboratories precluded full investigation of all of these, but attempts were made to contact, for follow-up information, the physicians who ordered the tests. All reporting physicians were requested to complete detailed Lyme disease surveillance forms; those physicians who did not return the forms were, in most cases, contacted by DHMH staff, and the surveillance forms were filled out with information provided by the physician by telephone. The surveillance forms used were those provided by the Centers for

Disease Control (CDC); although new forms were adopted by CDC and DHMH in mid-1990, most of the information requested remained the same. Information requested included age, gender, race, tick bite information when available, serologic results, and symptomatology.

For this study, CDC criteria were used to define a case: EM or at least one late manifestation with laboratory confirmation of infection.⁴ EM alone was sufficient to make the diagnosis, although the CDC amendment to include only cases where the lesion measured at least 5 centimeters was not implemented until September of 1990. Late manifestations included any one of the symptoms shown in Table 1 when there was no other disease or condition identified.

Laboratory confirmation, according to the CDC, is established when diagnostic levels of anti-*B. burgdorferi* anti-

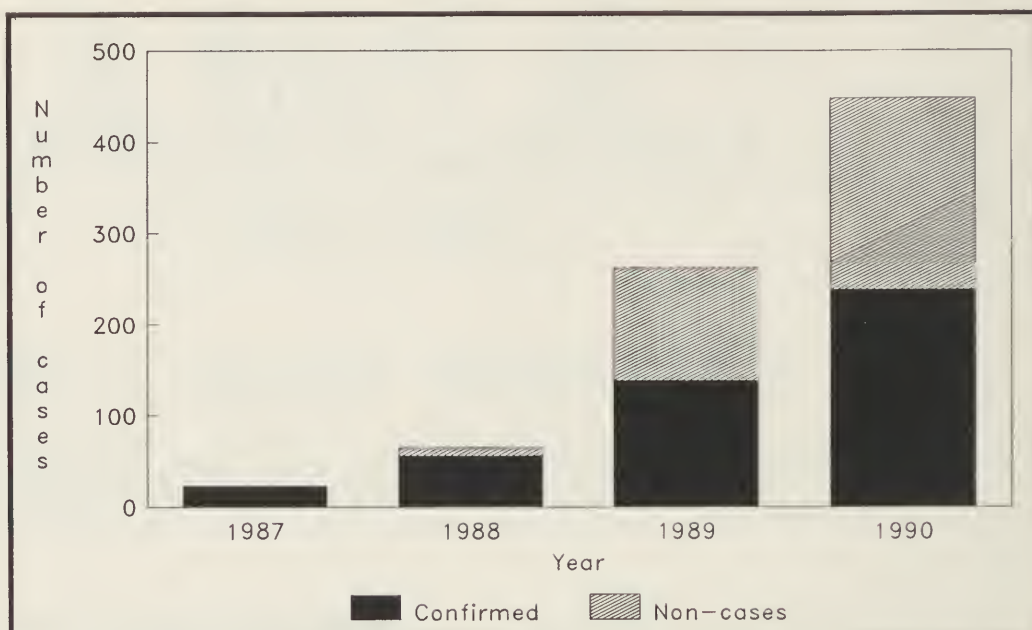


Figure 1. Lyme disease cases reported and confirmed in Maryland, 1987-1990

bodies are detected in serum or cerebrospinal fluid (CSF) by immunofluorescence assay (IFA) or enzyme-linked immunosorbent assay (ELISA), when the spirochete itself is isolated from tissue or body fluid, or when a significant change in antibody levels is detected in paired acute and convalescent sera.

A test was considered positive if it met any of the following criteria:

1. A physician reported a positive result, without providing additional information;
2. There was an IFA result of 1:256 or higher;
3. There was an ELISA result 10 percent greater or more than the lab normal, when the normal was provided;
4. There was an ELISA result greater than 1.10, when no lab normal was provided (since in most area laboratories, including the heavily utilized DHMH lab, the normal result is <1.0, often <0.8);
5. There was a change of at least 20 percent between acute and convalescent serologic results (either an increase or a decrease was considered positive, since it has been shown that a positive titer may decrease with appropriate antibiotic therapy); or
6. There was a biopsy or culture from patient tissue or body fluid positive for the spirochete.

Laboratory findings alone were not considered sufficient criteria for case definition, but were used in conjunction with the above clinical criteria.

Differences in proportions were tested using chi-square tests.

Results

The number of cases of confirmed Lyme disease in the state was 23 in 1987, 56 in 1988, 138 in 1989, and 238 in 1990, for a total of 455 confirmed cases. Reporting of the disease also increased dramatically, from only 23 cases (all subsequently confirmed) reported to the state in 1987, to 448

Table 1. Late manifestations of Lyme disease: Criteria for inclusion⁴

Musculoskeletal system

Recurrent arthritis (mono or polyarticular)

Nervous system

Lymphocytic meningitis

Cranial neuritis (particularly facial palsy)

Radiculoneuropathy

Encephalomyelitis**

Cardiovascular system

Acute onset of transient high-grade atrioventricular conduction defects, which may be associated with myocarditis (palpitations, bradycardia, bundle branch block, or myocarditis alone are not sufficient criteria).

*To be considered a case, the patient must have had at least one of the above without any other explanation for the condition, and laboratory evidence of Lyme disease as noted in the text.

**Requires laboratory confirmation of anti-*B. burgdorferi* antibodies in the CSF, with a higher titer in the CSF than in the serum (headache, fatigue, paresthesia, or stiff neck are not sufficient criteria).

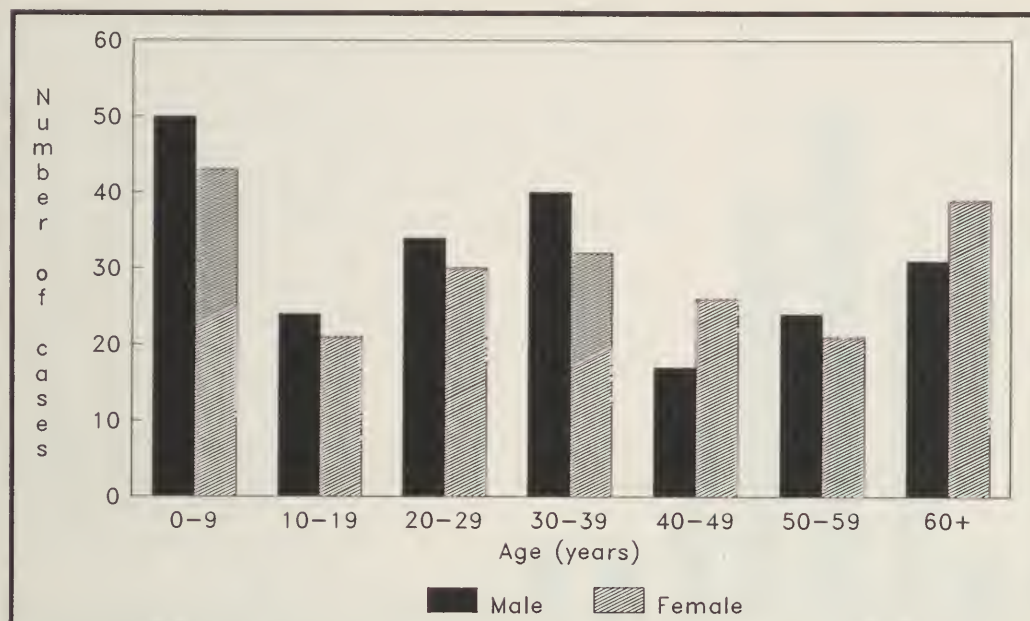


Figure 2. Age and sex distribution of Lyme disease in Maryland, 1988–1990.

reported cases in 1990 (Figure 1). Of the 448 cases reported in 1990, 40 were determined not to have Lyme disease, 138 were considered unconfirmed cases that did not meet the CDC criteria and were not included in the subsequent analysis, and 238 met the case definition. The remainder were cases with onset in previous years, or were patients visiting from another state.

Demographics. Ages of reported cases ranged from less than a year to 89 years. The median age was 31; the mean age was 33 (± 22.0). By ten-year intervals, the number of cases was 99 (0–9 years), 48 (10–19), 66 (20–29), 78 (30–39), 45 (40–49), 46 (50–59), and 72 (60 years and older). There were 225 males (49.6 percent) and 229 females (50.4 percent) among the cases (the gender of one case was not reported). Excluding the 23 cases from 1987, for which there were only limited data available, the sex ratio among different age groups was not statistically different (Figure 2).

Information on race was available in most cases for the years 1988–1990. Of 417 cases for which racial data were available, 387 (92.8 percent) were white, 22 (5.3 percent) were African-American, 6 (1.4 percent) were of Asian descent, and 2 (0.5 percent) were Native American.

Geographic distribution. Based on a 1990 population of 4.78 million, the statewide rate of Lyme disease per 100,000 was 0.48 in 1987, 1.17 in 1988, 2.89 in 1989, and 4.98 in 1990. All but one Maryland county (Garrett) reported cases of Lyme disease during at least one of the four years (Table 2). The counties with the highest average rates over the four years were Kent (30.83), Queen Anne's (20.62), Charles (10.13), and Cecil (9.11). The 1990 rates across Maryland (calculated for those counties with 5 or more cases) ranged from 1.1 to 56 per 100,000.

Tick exposure. Information on recent tick bites was recorded through most of 1990 (newer surveillance forms

requested only location of tick bites, not whether they had occurred). Definite tick bites were reported in 192 of the 436 cases (44.0 percent) where tick bite status was recorded.

For 1988–1990 cases, adults (46.6 percent) were more likely than children (31.3 percent) to have remembered or reported a tick bite ($\chi^2 = 8.89$, $p = 0.003$). Women (38.2 percent) reported bites less often than men (45.5 percent) but the difference was not statistically significant ($\chi^2 = 2.33$, $p = 0.10$). Patients with EM were more likely to have remem-

bered a tick bite (48.4 percent) than those without EM (20.6 percent; $\chi^2 = 24.9$, $p = 0.0001$).

Month of onset. Date of onset of symptoms (or first visit to a medical practitioner) was reported for 448 of the 455 cases. The peak onset occurred in June with 123 cases (27.0

Table 2. Geographic distribution of Lyme disease cases in Maryland, 1987–1990

County	1987	1988	1989	1990	Total cases	Average annual rate Per 100,000*
Allegany	0	0	0	1	1	0.33
Anne Arundel	4	12	14	28	58	3.39
Baltimore	1	8	18	27	54	1.95
Baltimore City	2	3	6	23	34	1.15
Calvert	0	2	8	7	17	8.27
Caroline	0	0	2	3	5	4.62
Carroll	0	0	1	7	8	1.62
Cecil	2	1	7	16	26	9.11
Charles	0	5	13	23	41	10.13
Dorchester	1	0	3	1	5	4.13
Frederick	0	1	3	3	7	1.17
Garrett	0	0	0	0	0	0
Harford	0	1	4	26	31	4.26
Howard	0	1	3	10	14	2.55
Kent	0	1	11	10	22	30.83
Montgomery	0	9	16	12	37	1.22
Prince George's	0	3	8	8	19	0.65
Queen Anne's	7	2	11	8	28	20.62
St. Mary's	0	0	3	6	9	2.96
Somerset	1	0	0	0	1	1.07
Talbot	2	5	2	1	10	8.18
Washington	0	0	1	3	4	0.82
Wicomico	2	2	2	6	12	4.04
Worcester	0	0	2	8	10	7.14
Other**	-	-	-	-	2	-
TOTAL	22	56	138	237	455	2.38

*Annual rate based on 1990 Maryland population estimates, US Bureau of the Census, US Department of Commerce.

**Other includes 2 cases with no county identified.

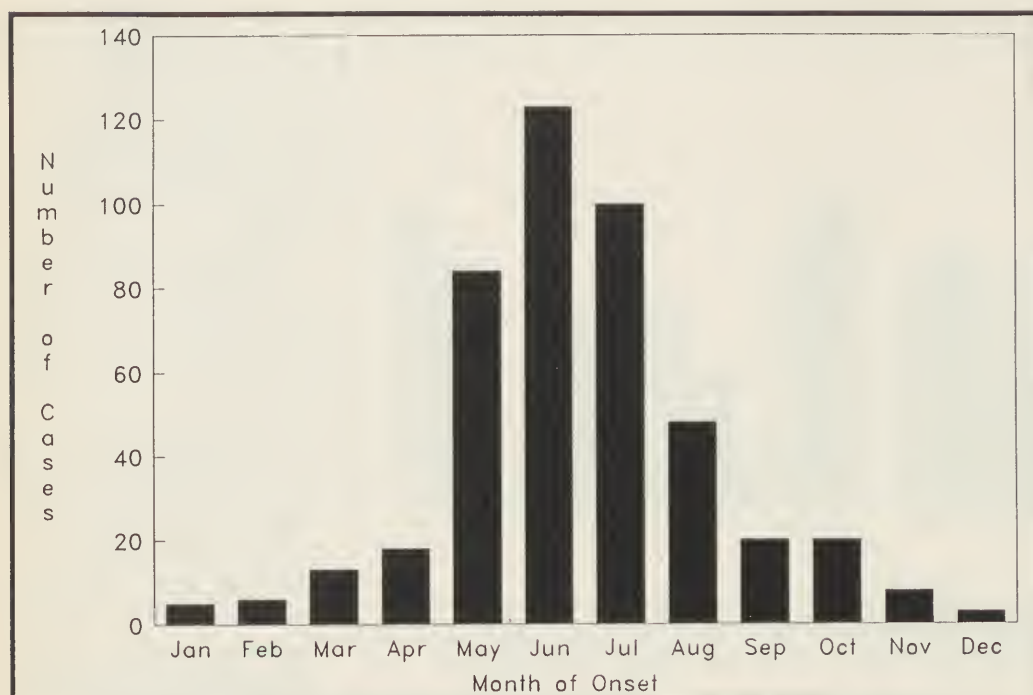


Figure 3. Monthly distribution of Lyme disease cases in Maryland, 1987–1990.

percent); the four-month period from May through August had 355 (78.0 percent) of the cases (Figure 3). For those reports in which both a date of onset and a date of a probable tick bite were recorded (169 cases), the duration between tick bite and symptoms varied between 0 and 1,045 days (excluding a small number of cases in which onset was reported prior to a tick bite). The mean duration between tick bite and onset of symptoms was 29.1 days (29.7 ± 64.5 for females, with a median of 10.0 days; 28.7 ± 113.9 for males, with a median of 7.0 days).

Symptoms. EM was the most common symptom, occurring in 342 (75.5 percent) of the 453 cases for whom this information was recorded. From 1988 to 1990, a rash of some

type (sometimes specified as EM by the physician) was recorded as the patient's chief complaint in 259 of 413 (62.7 percent) cases with recorded chief complaints. EM was more likely in men (81.4 percent) than women (71.2 percent; $\chi^2 = 6.15$, $p = 0.01$) and in whites (78.0 percent) than in non-whites (58.3 percent; $\chi^2 = 7.10$, $p = 0.008$). There was no significant difference between the proportion of EM reported in adults (76.8 percent) and in children (75.4 percent).

Chief complaints were recorded in 413 of 432 cases in 1988–1990 (data were not available for 1987). Diffuse systemic symptoms oc-

curred frequently, but symptoms related to late sequelae of the disease were uncommon. There was considerable variability in the description and detail of presenting symptoms. For example, EM, ECM, target lesion, and rash were all common descriptors. Table 3 lists presenting symptoms in decreasing frequency. After EM, the most common symptoms reported were arthralgias or arthritis, fever, headache, and fatigue/malaise/myalgias. These combined symptoms accounted for approximately 90 percent of the symptoms recorded at presentation to a physician.

Complications. Arthritis was the most frequent complication, occurring in 126 of 455 cases (27.7 percent). For 1988–1990 cases, women were more likely to have arthritic complications (32.5 percent versus 20.0 percent for men, $\chi^2 = 8.80$, $p = 0.003$). Children developed arthritis less often (22.4 percent) than adults (27.9 percent), but the difference was not significant.

There were 61 cases with neurologic complications (13.4 percent). For 1988–90, there were 19 cases of Bell's palsy (4.3 percent), 9 cases of meningitis (2.1 percent), and 6 cases of carpal tunnel syndrome (1.4 percent). There were no differences in neurologic complications by gender. Neurologic complications in general were more likely in patients without EM (33.3 percent) than with (7.2 percent); Bell's palsy in particular was more likely in patients without EM (13.7 percent) than with EM (1.5 percent). Other symptoms rarely reported included visual disturbance, migraine headache, discrete peripheral neuropathy other than carpal tunnel syndrome, and optic nerve edema.

Cardiac symptoms were reported in 12 of 455 cases (2.6 percent). The abnormalities noted included unspecified electrocardiogram (EKG) abnormalities in 4 cases and palpita-

Table 3. Presenting symptoms among 413 Lyme disease patients as recorded by physicians, 1988–90.

Symptom	Number of cases*	Percent
Erythema migrans or "rash"	259	48.9
Arthralgia/arthritis	81	15.3
Fever	48	9.1
Headache	40	7.5
Fatigue/malaise/weakness	28	5.3
Myalgia	23	4.3
Flu-like symptoms	23	4.3
Bell's palsy/cranial neuropathy	10	1.9
Stiff neck	8	1.5
Nausea/vomiting	5	0.9
Meningitis	2	0.4
Palpitations/tachycardia	2	0.4
Carpal tunnel syndrome	1	0.2
TOTAL	530	100.0

*Does not total to number of cases because of multiple chief complaints for a single patient.

tions in 7 cases. There was one case of documented tachycardia among those with palpitations. None of these patients were reported to have cardiac conduction abnormalities. Among the 1988–1990 cases with cardiac complications, there were 4 females (1.9 percent) and 8 males (3.6 percent), with 10 cases among adults (3.4 percent) and 2 among children (1.5 percent); neither difference was statistically significant.

Many of the cases had multiple organ system involvement, with a combination of cardiac, neurologic, and rheumatologic symptoms coexisting. For 1988–1990 patients, hospitalization was required in 56 of 407 cases with responses recorded.

Diagnostic confirmation. Serologic testing results are presented only for 1990 data, because follow-up on these results was more complete. Serologic testing was performed in 198 of 237 patients for whom this response was recorded; of these, 13 had no results reported. Since only patients with EM could be considered cases without serologic confirmation for the purposes of surveillance, all those without tests were patients with EM.

Of 185 cases for whom acute serologic test results were available, 117 (63.2 percent) were positive. Relatively few patients had convalescent testing, but of the 66 with convalescent results, 46 (69.6 percent) were positive. Of the 117 acute tests which were positive, there are convalescent results for 38; 6 of these (15 percent) were negative. Of the 68 cases with negative acute serologic results, only 28 had serology repeated; half of these turned positive.

Cultures were done and reported infrequently. There were no cultures reported in 1988, two in 1989 (neither positive), and 7 in 1990 (of which 3 were positive).

Discussion

The epidemiology of Lyme disease in Maryland during the years 1987–1990 has altered since an earlier report described cases occurring from 1984 to 1986.³ The number of cases per year has increased each year, from 10, 20, and 15 cases in 1984, 1985, and 1986, respectively, to 23, 56, 138, and 238 cases per year in 1987, 1988, 1989, and 1990, respectively (a thirteen-fold increase). This pattern is consistent with the sixteen-fold increase in Lyme disease seen nationally, from 497 cases in 1982 to 7,997 cases in 1990.⁵ Since Lyme disease became reportable in 1989, the total number of cases reported has increased, while the percentage of cases that are confirmed has decreased.

The demographics of the disease are similar to that reported previously, although with some important differences. From 1984 to 1986, the male to female ratio of cases was 3:1; from 1987 to 1990, the sex ratio was approximately equal, although there were gender differences in some symptoms (EM) and complications (arthritis/arthralgias). The proportion of adults has increased since the previous study, with a median age of 31 years, compared with 15.5 years previously. The difference may be due to increasing recognition or reporting of Lyme disease among physicians treating adults. Most

patients (92.8 percent) were white, although whites make up only 69.9 percent of Maryland residents (1990 estimate, US Bureau of the Census, US Department of Commerce). Only 5.3 percent of cases were African-American, although African-Americans make up 24.8 percent of Maryland's population. Some of this difference is probably due, in part, to the different geographic distribution of African-American and white Maryland residents; African-Americans are more likely to live in and around Baltimore and in Prince George's County, areas which had low rates of Lyme disease. Rates of Lyme disease were highest in Kent, Queen Anne's, Charles, Cecil, and Calvert counties. This is similar to previous years. The highest rates were found in rural areas, as expected. Three of the five counties with the highest rates are on the Eastern Shore of Maryland. It is difficult to explain the disproportionately high rates in some of these counties in comparison to adjacent counties (especially the Kent County rate), but differences in reporting or diagnosis, or in statistical artifact may account for these observations. Western Maryland (Garrett, Allegany, and Washington counties) had few cases. Charles and Calvert counties had higher rates than neighboring St. Mary's and Prince George's counties, although in the case of Prince George's County the lower rate may be due to the county's heavy urbanization near Washington, DC. Along the northern border of the state, the rate of Lyme disease decreased with increasing distance from the Eastern Shore (Cecil County, 9.11; Harford, 4.26; Baltimore, 1.95; and Carroll, 1.62). Frederick County, in north central Maryland, also had a low rate of Lyme disease over the four years (1.17), but is currently experiencing an increase in its deer population.

Onset of the disease followed the same pattern as in previous years, with the majority of cases occurring in the summer months, peaking in June and July. Few cases had onset before May or after August. This is expected, since the tick is most active in the summer, when people are more likely to be outdoors with exposed skin.

Fewer than half of all patients recalled a specific tick bite. The spread of Lyme disease has been correlated in other states with increases in tick populations,⁶ but recollection of a tick bite in this study is probably a poor marker of actual tick exposure because of the low number of tick bites reported. Recall of tick bite was more common in patients presenting with EM than in those without EM. EM was present in 75.5 percent of patients, which is similar to previous years. The most common late complication noted was arthritis, which is consistent with other studies.²

Serologic results were similar to those in the previous study, with 63.2 percent positive during the acute phase. This result is consistent with the observation that antibody response often follows the initial EM phase. It would have been useful to compare initial negative results with convalescent results, but these were available in few cases. Of the 38 cases in which an initial positive result was followed by a convalescent test, 6 (15.8 percent) turned negative. Although the

serologic results must be interpreted with caution, given the differences among labs and reporting styles, as well as the known poor reliability of these tests, both within and between laboratories,⁷ this disparity between acute and convalescent results is not unexpected, since it has been shown that positive Lyme titers may decline with appropriate antibiotic treatment.

Laboratory confirmation was complicated by the variety of diagnostic methods and laboratories involved, by incomplete reporting of results (normal values for the laboratory and test were omitted more often than not), and by a change in the way the information was requested on the surveillance forms part way through 1990 (the later CDC forms requested a report of positive or negative from the reporting physician, while the forms used earlier requested the test values).

The factors responsible for the increased number of cases of Lyme disease include increased recognition of the disease by the public and physicians, increased reporting by health professionals, and an increased incidence rate. The latter may be due, in part, to an increasing deer population in the north-eastern US, including Maryland. Until residents in endemic areas learn to protect themselves with appropriate outdoor preventive habits, the next line of defense against Lyme disease is early recognition and treatment. As physicians become more familiar with the disease and with the Maryland reporting requirement, reporting should also increase. It is hoped that analysis of surveillance data provided by

physicians in the coming years will provide information useful for the prevention and treatment of Lyme disease, as well as improvement in the precision of diagnosis.

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Acknowledgments

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PHYSICIAN'S RECOGNITION AWARD

During February 1992, the physicians listed below received the American Medical Association's (AMA's) Physician's Recognition Award. Established in 1968, the Award's purpose is to encourage physician participation in continuing medical education and to recognize those physicians who have voluntarily completed programs of continuing medical education.

Wayne Leslie Barber
Sanders Harris Berk
Carole Mae Booth
Denis Lee Bourke
Frederick S. Caldwell
Paul J. Christenson

Charles Michael Citrin
Huell Edward Conner
Daniel David Cowell
Robert David Deitz
William Bryan Gamble
Perry Hookman

Stephen Noland Jones
Scott Marshall Panzer
Angela Ruth Peterman
Jacob E. Teitelbaum
Larry Evans Tune
Mary Margaret R. Watson

The clinical use of histamine-2 receptor antagonists

Robert J. Michocki, Pharm.D. and James P. Richardson, M.D.

From the University of Maryland Medical System where Dr. Michocki is associate professor, School of Pharmacy, and clinical associate professor, School of Medicine; and Dr. Richardson is assistant professor, Division of Geriatrics, Department of Family Medicine.

Histamine-2 receptor antagonists have been available for fifteen years for the treatment of peptic ulcer disease and related disorders. While very safe, clinicians need to know correct dosing guidelines, drug interactions, and side effect profiles. Long-term therapy should be reserved for patients at high risk of recurrence.

The introduction of cimetidine in 1977 revolutionized the therapeutic management of peptic ulcer disease. Prior to the availability of histamine-2 (H_2) blocking drugs, traditional methods of managing peptic ulcer disease included antacids every two hours alternating with milk; bland diets; bed rest; anticholinergics; and avoidance of coffee and tobacco products. Patients eventually improved but at the expense of constipation or diarrhea, depending on the antacid chosen. During that time, a significant loss of economic productivity also occurred as a result of prolonged hospitalizations. Today, a variety of new therapeutic modalities are available for the management of peptic ulcer disease. These include several H_2 receptor antagonists, sucralfate (Carafate), omeprazole (Prilosec), anticholinergics, and antibiotics, as well as traditional antacids, which now have greater acid neutralizing capacities and enhanced palatability.

Following the introduction of H_2 blocking drugs, hospitalizations for peptic ulcer disease (PUD) and deaths from PUD have declined.¹⁻⁴ Of all the available therapeutic modalities, H_2 receptor antagonists are by far the most frequently prescribed drugs for the treatment of acid peptic disorders. Ranitidine was the third most frequently dispensed medication (new and refills) in 1990, exceeded only by amoxicillin and digoxin.⁵ Antisecretory drug prescriptions represented a wholesale market of over \$2 billion in 1989.⁶

Indications and dosage

Since cimetidine was released in 1977, three other histamine-2 antagonists have been released: ranitidine (Zantac), famotidine (Pepcid), and nizatidine (Axid). These drugs have equally high healing rates for patients with peptic ulcer disease. Indications, dosing regimens, and product summaries are listed in Table 1. All available H_2 receptor antagonists are approved for acute and maintenance therapy of duodenal

Table 1. Histamine-2 receptor antagonists product information

Generic name—*Cimetidine*

Brand name—*Tagamet*

Oral dosage forms	Indications	Maximum daily dosage	Duration of therapy	Dosage adjustments	Drug-drug interactions	Drug-disease interactions	Adverse drug reactions
Tab	Duodenal ulcer:			600 mg/d in severe renal impairment	Warfarin-like anticoagulants	Caution in pregnancy and lactation	GI: Diarrhea
200 mg	Short-term active	1,200 mg	4–8 weeks		Phenytoin		CNS: Dizziness
300 mg	Maintenance	400 mg	6 months		Ketoconazole		Headache
400 mg	Active benign gastric ulcer	1,200 mg	6 weeks		Propranolol		Reversible confusional states
800 mg					Chlordiazepoxide		Endocrine: Gynecomastia reversible impotence
Liquid	GERD (gastro-esophageal reflux disease)	1,600 mg	Up to 12 weeks		Diazepam		
300 mg/5 mL	Hypersecretory conditions	1,200 mg	Clinically indicated		Certain tricyclic antidepressants		
					Theophylline		
					Metronidazole		

Generic name—*Famotidine*

Brand name—*Pepcid*

Oral dosage forms	Indications	Maximum daily dosage	Duration of therapy	Dosage adjustments	Drug-drug interactions	Drug-disease interactions	Adverse drug reactions
Tab	Duodenal ulcer:			Creatinine clearance	Ketoconazole	Caution in pregnancy and lactation	Fever
20 mg	Short-term active	40 mg	6–8 weeks	<10 mL/min			Fatigue
40 mg	Maintenance	20 mg		max 20 mg/d			GI: Diarrhea
Oral suspension	Active benign gastric ulcer	40 mg	8 weeks				Cholestatic Jaundice
40 mg/5 mL	Hypersecretory conditions	80 mg, up to 640 mg/d	Clinically indicated				Vomiting
							Nausea
							CNS: Headache
							Dizziness
							Depression
							Anxiety

Generic name—*Nizatidine*

Brand name—*Axid*

Oral dosage forms	Indications	Maximum daily dosage	Duration of therapy	Dosage adjustments	Drug-drug interactions	Drug-disease interactions	Adverse drug reactions
Cap	Duodenal ulcer:			Creatinine clearance	Ketoconazole	Caution in pregnancy and lactation	Sweating
150 mg	Short-term active	300 mg	4–8 weeks	Short-term active:			Somnolence
300 mg	Maintenance	150 mg	1 year	20–50 mL/min,			Urticaria
	GERD (gastro-esophageal reflux disease)	300 mg	Up to 12 weeks	150 mg/qd			Reversible confusional states
				<20 mL/min,			
				150 mg/q2d			
				Maintenance:			
				20–50 mL/min,			
				150 mg/q2d			
				<20 mL/min,			
				150 mg/q3d			

Generic name—*Ranitidine*

Brand name—*Zantac*

Oral dosage forms	Indications	Maximum daily dosage	Duration of therapy	Dosage adjustments	Drug-drug interactions	Drug-disease interactions	Adverse drug reactions
Tab	Duodenal ulcer:			Creatinine clearance	Ketoconazole	Caution in pregnancy and lactation	Headache
150 mg	Short-term active	300 mg	4–8 weeks	<50 mL/min,			CNS: Dizziness
300 mg	Maintenance	150 mg	1 year	150 mg/qd			Insomnia
Liquid	Active benign gastric ulcer	300 mg	6 weeks				GI: Diarrhea
75 mg/5 mL	GERD (gastro-esophageal reflux disease)	300 mg	6 weeks				Nausea/Vomiting
	Hypersecretory conditions	300 mg, up to 6 g/d	Clinically indicated				

ulcers. All are effective in healing gastric ulcers, although nizatidine is not currently approved for this indication. Although relapses of gastric ulcers may be prevented with H₂ receptor antagonists, none of the currently available products are approved for maintenance therapy of gastric ulcer. Cimetidine, ranitidine, and, most recently, nizatidine, are also approved for the treatment of gastroesophageal reflux disease. Cimetidine, famotidine, and ranitidine also are approved for the treatment of hypersecretory conditions, such as Zollinger-Ellison syndrome, although large doses frequently are necessary.⁷

Full-dose H₂ blocker therapy for acute peptic ulcer disease and gastroesophageal reflux should not be prescribed for longer than eight weeks, as most studies indicate complete healing within that time.^{7,8} Some patients who are at high risk for relapse will require a longer course of treatment at a reduced dose. Although reduced dose maintenance therapy with H₂ receptor antagonists is effective in preventing symptomatic relapses in patients with duodenal and gastric ulcers, there are a number of reasons that physicians may not want to use these drugs for prophylactic therapy. First, about one-fourth of new patients with peptic ulcer disease will not experience relapse; as Feldman and Burton state,⁷ symptomatic relapses can be treated with short courses of H₂ blockers. Second, maintenance therapy is expensive, with an average cost of \$400 per patient per year. Lastly, the long-term safety of these drugs has not been established with certainty, since cimetidine has been on the market for only fifteen years and the other H₂ blockers for considerably shorter periods.⁷ For these reasons, many practitioners restrict maintenance to high risk patients (Table 2).

Duodenal ulcers are less likely to heal in patients who smoke cigarettes. Long-term maintenance therapy may be beneficial for smokers with duodenal ulcers, given the difficulties in getting patients to quit smoking.⁹ Nonetheless, physicians should encourage smokers with ulcers to quit, as

smokers are more likely to quit when physicians explicitly link tobacco use to a health problem.¹⁰

H₂ receptor antagonists can also prevent NSAID (non-steroidal anti-inflammatory drug) induced duodenal (but not gastric) ulcers in patients with arthritis, but whether this approach will be cost-effective in patients without a history of duodenal ulcer is uncertain.⁷

Pharmacokinetics

The absorption of the four H₂ receptor antagonists is rapid, with an average time to peak serum level of 1 to 3 hours. Serum half-lives of the H₂ receptor antagonists range from 1.5 to 4 hours in normal subjects. The elimination of all H₂ antagonists occurs by a combination of hepatic metabolism, glomerular filtration, and renal tubular secretion. Cimetidine, ranitidine, and famotidine are metabolized principally by the liver, while renal excretion is the main route of elimination for nizatidine.⁷ All four of these drugs require dosage reduction in the presence of renal disease, and cimetidine dosage should be reduced in patients with severe liver disease (Table 3). Dosage reduction may also be necessary in the elderly.⁷

Adverse effects

As a group, these drugs are safe with relatively few adverse effects (Table 4). All available H₂ blockers penetrate the cerebrospinal fluid, and cimetidine, ranitidine, and famotidine

Table 2. Persons at increased risk for duodenal ulcer recurrence⁹

Persons who smoke heavily
Persons with a long duration of symptoms (several years)
Patients with a previous history of an ulcer complication
Gastrointestinal bleeding
Perforation
Obstruction
Geriatric patients who are poor surgical candidates
Patients requiring indefinite long-term therapy with NSAIDs, aspirin, or steroids
Diseases associated with an increased incidence of peptic ulcer.
Chronic obstructive lung disease
Alcoholism with cirrhosis
Rheumatoid arthritis
Jejunum-ileal bypass for morbid obesity
Systemic mastocytosis
Basophilic leukemia
Chronic renal failure (adjust dosage)

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Table 3. Dose of H₂ blockers in renal failure⁷

Drug/Creatinine Clearance	Dose*
Cimetidine	
>30 ml/min	800 mg/day
15-30 ml/min	600 mg/day
5-14 ml/min	400 mg/day
Ranitidine	
<50 ml/min	150 mg/day
Nizatidine	
20-50 ml/min	150 mg/day
<20 ml/min	150 mg every other day
Famotidine	
<10 ml/min	20 mg/day or 40 mg every other day

* Dose that is required to heal duodenal ulcer

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Table 4. Adverse reactions associated with H₂ receptor antagonists⁷

Reactions	Percent
Diarrhea	1-3
Headache	2-3
Muscular pain	2
Constipation	1

Other side effects occurring with a prevalence of less than 1 percent include mental confusion, somnolence, gynecomastia, galactorrhea, impotence, loss of libido, blood dyscrasias, myalgias cardiovascular effects, skin reactions, hepatitis, and allergic reactions.

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have been reported to produce mental confusion in some patients, usually with high dose parenteral therapy. In ambulatory patients receiving oral therapy, central nervous system side effects, including mental confusion, have been reported to occur infrequently. While all four H₂ receptor antagonists have an excellent safety profile, more is known about ranitidine and cimetidine because they have been used in more patients for a longer period of time. Famotidine, nizatidine, and ranitidine differ from cimetidine in that long-term treatment at high doses, such as those used to treat hypersecretory states, is not associated with antiandrogenic adverse effects, such as gynecomastia and reduced libido. Therefore, these drugs may be preferred over cimetidine when high dose therapy is required.

Drug interactions

Drug-drug interactions should also be considered when choosing an H₂ receptor antagonist. Therapeutic doses of ranitidine, famotidine, and nizatidine do not significantly affect the elimination of drugs that are metabolized by the cytochrome P-450 mixed-function oxidase system. In contrast, cimetidine has been reported to decrease the hepatic clearance and increase the effect of theophylline, warfarin, phenytoin, lidocaine, and other drugs that are metabolized by hepatic microsomal enzymes. In addition, cimetidine, and to a lesser extent ranitidine, can decrease the renal tubular secretion of procainamide and N-acetyl procainamide and may potentially cause toxicity. There are also anecdotal case reports implicating ranitidine with rising serum theophylline concentrations. Therefore, it would seem prudent to closely monitor patients for signs of theophylline toxicity if ranitidine is added to a regimen containing theophylline.¹¹ Even though clinically significant drug interactions may occur with cimetidine and to a lesser extent with ranitidine, concurrent use of interacting drugs is not always an absolute contraindication. Concurrent use may be appropriate if proper monitoring and/or dosage adjustments are made. Practically, however, it is easiest to use a noninteracting H₂ blocker in patients receiving an interacting drug with a narrow therapeutic index. Alternatively, a lower daily dose and once-a-day dosing may reduce the magnitude of these potential drug interactions, as hepatic enzyme interactions with cimetidine appear to be dose related. However, smaller doses of cimetidine may be associated with slower rates of ulcer healing. Sucralfate is another option in patients taking multiple drugs, and its lack of systemic effects makes its use particularly appealing for elderly patients.

A drug interaction common to all commercially available H₂ receptor antagonists occurs when ketoconazole (Nizoral) is administered concurrently with an H₂ blocker. The increase in gastric pH impairs the dissolution and absorption of the ketoconazole. This does not occur with fluconazole (Diflucan).

Duplicative therapy

No more than one H₂ receptor antagonist should be pre-

scribed at a time. No data suggest that combinations of H₂ receptor antagonists improve outcome. In addition, even though the mechanism of action is different, the addition of misoprostol (Cytotec), omeprazole, or sucralfate with any H₂ receptor antagonist is no more effective than either drug used alone. Anecdotal clinical experience may suggest that a minority of patients with severe disease may respond to a combination of an H₂ receptor antagonist with sucralfate, but there is little justification to use this combination on an empiric basis.

Summary

All four H₂ receptor antagonists are equally effective when given in equipotent doses. Full dose therapy with these medications should be limited to eight weeks; maintenance therapy can be continued at a reduced dosage in patients with a high risk of relapse. Dosage may need to be modified in the elderly and in patients with renal disease. Drug interactions are more likely to be encountered with cimetidine and, to a lesser extent, ranitidine. Famotidine and nizatidine, although newer, appear to have less potential for interactions. There is little justification for combining other gastric antisecretory drugs with H₂ receptor antagonists. The indication, H₂ blocker dose, and duration of therapy should be clearly defined when initiating treatment with these efficacious but expensive drugs.

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Normal sexual development of children: Physician roles in bridging gaps in parent-child communication

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Physicians have opportunities to help a child have pride about his or her body, support the child's sexual self, and encourage shame-free limit setting. By supporting a parental coalition that is resilient and indivisible, physicians help children value their gender role, and may influence the outcome of sexual orientation.

Credit for the scientific approach to studying sexual behavior belongs primarily to physicians and not just to those who are psychiatrists. Contemporary with Freud,¹ Havelock Ellis,² an English physician around the turn of the century, turned the field from Victorian misimpressionism to scientific methodology. Van de Velde,³ Dickinson,⁴ and Masters^{5,6} are among other physicians credited with major advances in the field.

All physicians, even those not specifically treating children, have opportunities to influence the development of children. Progress in understanding family systems and, particularly, the impact of parents' attitudes and behavior on children, allow for more informed and precise therapeutic intervention.⁷⁻¹⁰

Repressing and projecting unacceptable thoughts and feelings occur frequently with sexual impulses and conflicts. The traditional view attributes this to our society still being partly in the wake of repression from the Victorian era, which makes it difficult for people to fully accept their own sexuality. This, in turn, makes it difficult for parents to fully accept their children's sexuality. Physicians have the opportunity to facilitate parent-child understanding and communication concerning normal childhood sexuality.

Recognizing parenthood as a developmental phase

The first separation and individuation phase of early childhood described by Mahler et al,¹¹ and the second individuation phase of adolescence described by Blos,¹² have been joined by the third individuation phase, that of parenthood, described by Colarusso.¹³ Complementary to these stages of psychological development are the equivalent components

of parenting processes, performed at times by teachers and mentors, as well as by physicians who work closely with children or their parents. The concept of parenthood as a developmental phase was actually originated by Benedek.¹⁴ This concept is relevant to the development of children because parents and equivalent others, relive and rework stages of their own development through their children, and may unwittingly draw their children unduly into this process.

Therefore, when a physician is listening to a parent describe a child's behavior, including sexual behavior, it is often helpful to ask parents what they recall about themselves, including their own sexual awareness when they were their child's age. It is often worthwhile to ask parents about their perception of their own parents' attitudes concerning sexual matters, keeping in mind that such perceptions may unconsciously be defensively distorted. Activating such thought processes may help parents discover that they may be automatically reacting to their child under the influence of what they themselves experienced, or believe they experienced, around that age. They may then recognize that they are projecting aspects of themselves onto the child, including expectations that may not apply to their child.

The physician's use of self in evaluating children

When evaluating a child who is reported to have a sexual problem, physicians can try to recall their own perceptions of sexuality when they were the child's age. This is more easily said than done because of the frequent presence of amnesia for such experiences. Though not providing a standard by which to rigidly evaluate the child's behavior, these recollections may provide clues to help understand what the child might be experiencing. The physician also needs to sort out those feelings that are primarily the physician's own from those induced in the physician by the child. For example, the physician may be aware of feeling judgmental about a child. These feelings may not represent how the physician truly feels but instead may be a reflection of how the child's parent or parents feel. This is because children sometimes unwittingly project their perception of their parents' disapproval of them onto the physician, inducing the feelings of disapproval in the physician. The physician needs to recognize these as transferred feelings and resist the tendency to counter-transfer feelings back onto the child by reacting critically (or seductively if such are the feelings originally transferred). Instead, the physician can reflect on the induced feelings as a valuable source of information concerning family processes.

Gender identity

The most important psychological determinant of the child's gender identity is the labeling of the child as a boy or a girl. Once this occurs, parents and others automatically bring to bear their full repertoire of expectations and interactions appropriate to that gender. Boy infants receive such comments as "Oh, he's a fighter!" Girl infants receive such comments as "Only a lady would keep us waiting so long!" Researchers using a Baby X technique in which the same

infant is variously identified as male or female to different adults, found the adults' responses to conform to the designated gender rather than to be congruent with the baby's actual gender.¹⁵ These preset responses highlight the importance of delaying assignment, with explanation to the parents, where the genital anatomy is ambiguous, as well as conducting the clarifying testing and decision making as quickly as possible.

Concerning the normal situation, Freis,¹⁵ a pediatrician, explains to the parents at one of the early well-baby visits that parents are communicating with their infants whenever they handle them. He explains that as parents, we express, nonverbally, a statement of gender to the baby; that is, we teach our children their gender identity and role by the way we speak to and handle them. Through a long series of such interactions, parents reinforce behavior perceived to belong to their child's gender and discourage behavior perceived to be associated with the other gender. By the time an infant is approximately 18 to 24 months of age, he or she has got the message and can usually identify both self and others by gender.¹⁵ This differentiation is consolidated in practically all children by 4 years of age.

The physician may detect parental ambivalence or outright parental disappointment about the child's being a boy or a girl before actual problems with gender identity emerge. Isolated imitation of opposite-sex mannerisms or occasional cross-dressing in the young child is not usually cause for concern. In contrast, consistent opposite sex behavior in the young child is cause for concern and intervention should begin as early as possible. Both parents should be included in the treatment with the child.¹⁶

Intervention is necessary not only to try to prevent transsexualism,¹⁶ but also to maximize chances of a later heterosexual outcome.¹⁷ (For some individuals a homosexual orientation will be the natural outcome, because of heredity¹⁸ or as a result of prenatal exposure to hormones.^{19,20} These individuals may at some point need their physician's help in accepting their sexuality, especially since society is heavily biased against nonheterosexual orientation.) A long-term prospective study with a comparison group revealed that approximately two-thirds of boys, ages 3 1/2 to 12 years, who were diagnosed as having a gender identity disorder of childhood, were found to be either bisexual or homosexual when reevaluated in later adolescence or young adulthood. The great majority had had no intensive psychotherapy during the interval; those receiving psychotherapy constituted too small a group for meaningful evaluation of treatment measures.²¹

Physician/parent comfort and sex education of children

Most important in sex education of children is the comfort level of the parents concerning sexual matters, at least as perceived by the children.

A retrospective questionnaire study of college students revealed that males' comfort regarding physical contact and affection correlated positively with their perception of their father's comfort ($p < 0.001$) and their mother's comfort ($p < 0.01$)

in speaking about sex, as remembered from childhood. For females, their comfort regarding physical contact and affection correlated positively with their remembered comfort in talking about sex with their mother ($p < 0.001$) and with their father ($p < 0.01$) when the women were children.²²

As physicians become more comfortable responding to parents' concerns regarding their children's sexuality, they increasingly provide good role models for parents who will then be more comfortable responding to their children's sexual concerns.

When children ask questions about sexual matters, it is best for parents to try to reach an awareness of the child's current understanding of the topic and to identify the child's current concern. This helps avoid the common mistake of telling the child too much at once. A well-known example is that of the parent who related a comprehensive story of the birds and the bees to her child in response to the question, "Where do I come from?" only to discover that the question was merely an inquiry regarding the geographical state in which the child was born.

Similarly, when parents ask physicians whether their child's sexual behavior is normal or not, physicians would do well to inquire about the parents' specific concerns, including what makes the parents think their child's behavior may not be normal. Such exploration may uncover incorrect information, erroneous beliefs, judgmental attitudes, or conflict within the parents themselves that requires further consideration. Even when the result confirms that the child indeed has a significant problem requiring professional intervention, such evaluation may help reveal to the parents the ways in which the parents contribute to the problem.

Another common mistake parents often make in response to questions by children is to fabricate an explanation with the intention of correcting it gradually as the child matures. The rationale usually involves protecting the child from factors that he or she is not ready to hear. The result may be, however, to establish a basis of distrust and/or confusion in the parent-child communication over sexual matters.²³ It is better to simply refrain from telling children what one has determined they are not yet ready to understand. If the parents do not know the right way to respond or are too anxious themselves to respond, then it is best to put off the answer until they are more composed and clearer as to how they wish to respond to their child. A delayed response is better than a hasty, anxious, and erroneous response.

Similarly, the physician who feels put on the spot by a parent's question concerning a child's sexual activity, can tell the parent he or she would like to research the question further, as one might do for other matters. This provides time for further consideration, including exploring one's own anxieties and sorting out one's own feelings, before resuming discussion of the matter at the next visit. There is certainly enough difference in opinion among the experts that no physician need feel inadequate in not coming up with the one best answer to all questions. As noted in the *Nelson Textbook of Pediatrics*, "All adults, and physicians above all, should be

extremely cautious in inferring meaning for the current or future sexual development of children from any isolated act or even a series of sexual acts."²⁴ It is helpful, however, to have some frame of reference and the following, while it can not be all-inclusive, will attempt to provide some structural framework.

The child's sexual self

It has been said that there are two theories of personality—the onion theory and the artichoke theory.²⁵ Peeling away layers of the onion results in nothing being left, whereas peeling away layers of the artichoke leaves a core at the heart. There are data suggesting that there is an irreducible sexual component within the core of the individual. This does not mean that it cannot be kept from developing and maturing.

To some degree, the infant is a sexual being from birth. Male infants, from birth or a few days after birth, have penile erections, and female infants are physiologically equipped for vaginal lubrication. Though initially such responses seem to be a physiologic reflex associated with urination and defecation, by the second half of the first year, accidental contact of hand to genitals leads to the discovery of pleasurable sensations and then to elaborate exploration in the form of pokes, pulls, and strokes.²⁶ In the process of self-exploration, infants come to recognize their genitals as especially sensitive body parts which, when stimulated, give them a sense of enjoyment.

Careful observers of young children believe sexual arousal occurs during focused genital self-stimulation beginning around 15 to 18 months of age.^{27,28} Some researchers believe this to be a central focus for the organizing of experience.²⁹

According to Chess and Habbibi,¹⁶ although there is no rule by which the normal frequency of masturbation can be judged, a child who is engaged in repeated daily autostimulation or prefers sexual games to all other activities, is in need of a psychiatric evaluation.

If parents' concerns appear to result from a lack of knowledge about childhood sexuality, the parents need reassurance that their child's behavior is not abnormal and is simply one part of his or her development of body awareness. Parents' objections to masturbation might have more to do with the time and circumstances under which their child's masturbation occurs. The parents need to be reminded that the child has not yet learned the social norms about the appropriate time and place for sexual behavior. The parents can be counseled to share these norms matter-of-factly with their children. It is important not to chide or shame children which could lead to feelings of anxiety, guilt, and fear concerning sexual activity. Children are susceptible to such guilt induction because they may already be struggling with guilt arising from their sexual fantasies. Harsh external interference may result in fixation on an internal process that otherwise would be satisfactorily resolved.

Excessive masturbation, where it is determined to not result from local irritation or inflammation, may be a symptom of general psychological disturbance for which the child uses sexual self-stimulation for comfort and consolation. At

times, it may serve less as a source of pleasure and more as a way of relieving tension and stress.

Where limit setting is necessary, the best guideline appears to be using the least intrusive method necessary to get the child to cease the behavior. It is generally best to interest the child in substitute activity or to distract the child in a way that allows face-saving rather than to put the child directly on the spot.

Sometimes, rather than indicating an abnormality in their child's behavior, the difficulty may stem from the parents' own sexual anxieties and doubts or from their inability to accept their child's having sexual feelings. At times, the child may be unwittingly used as a distraction from discord in the parents' marriage, sometimes a sexual problem or dysfunction. Having judged that the masturbation is not excessive, the physician does well to explore with the parents the possible reasons for their concerns, offering advice or making referral as needed.

It is natural for children to be curious about other children's and their parent's genitals, as well as their own. How else can the young scientist understand why all the fuss is made about the distinction between the sexes and how his or her genitalia differs from others.

In some cultures, the expression of sexual activity is more acceptable and is viewed as a childhood rehearsal for later mature sexual behavior. Nevertheless, limits may need to be set if not contained within acceptable boundaries. Abrupt sudden onset of intense sexual play may be an indication of sexual abuse, the possibility of which should be explored particularly if other factors raise this suspicion. The importance of detecting and stopping sexual abuse of children as quickly as possible is heightened by our increased understanding of the profound effects on the victims. In addition to the extreme disruption of the children's general psychological development, their sexual development is usually thrown completely off track, with a multitude of later consequences.³⁰⁻³²

Parents can help children put their curiosity into words.³³ For example, the child may not find the vagina by searching and is greatly helped by the parents' explanation as to its existence. Children who constantly intrude on adults' privacy can be told that it is natural for children to want to know how grownups are made and that they can ask what they want to know.

The child's persistent efforts to observe parents in the nude in a household where everyone covers up is often an indication that parents need to stop anxiously covering themselves when the child unexpectedly enters the room. Although some sex educators, such as Goghros,²³ believe parents need to occasionally allow the children to casually see them in the nude with follow-up explanations if the child appears interested, this has significant risk because it is difficult to gauge what might be overstimulating to the child. A safer way to practice what some³⁴ call sexual learning, in which parents create opportunities to explain sexual matters rather than waiting passively for the child to ask, is simply to invite questions when the child appears ready and needing to have information.

When children do ask about sexual matters, this is an opportunity not to be missed. Particularly for older children and adolescents, the inclusion of love and caring in discussions of sexual matters helps place sexuality in this broader context, shapes healthy sexual values, and may help prevent sexual activity for which the child is not sufficiently mature.

Physicians have the opportunity to provide a role model for parents in regard to openness and initiative about sexual issues by including in the review of symptoms, usually in the urogenital portion, a question regarding sexual functioning.

Gender role development

Helping the child have positive feelings about his or her body, either directly or through the parents, is one way of fostering a healthy sense of the child's masculinity and femininity. Other important determinants include the value placed by each parent on the child's masculinity or femininity, as well as each parents' demonstrated respect for their partner's gender role.³⁵

A girl needs to discover that being a girl has special satisfactions for her. A mother who has found satisfaction herself in being a woman will likely communicate this without words. A father who is pleased at having a daughter and who values femininity for itself, will give great impetus to the process of feminine identification in his little girl.³³

If the girl is a tomboy, the father might have to temper his romping with her to some degree. However, most important is to strengthen and promote the feminine side of the child. The satisfactions gained through playing boy will eventually diminish, without conflict over jeans, hairdo's, and manners. The boy pose may then be given up because being a girl has greater satisfactions. This does not necessarily require special mother-daughter jaunts, though this may help. Identification is achieved primarily through love and the wish to emulate a beloved person.³³

Children will often test the parents' relationship with one another and may stress the parental coalition. Whether or not parents know about or believe in an Oedipus complex, intense love attachments are a normal part of child development, particularly during the years 3 to 7. Children explore the limits of their masculinity or femininity by challenging the parent of their own gender, which may expose that parent's vulnerabilities.

Whether or not Jimmy's father knows why Jimmy is challenging his authority with a bedtime tirade, the father is obliged to deal with the behavior. In sending Jimmy off to his room, he is saying in effect, "I am your father and you are only a little boy."³³ The father needs to remain emotionally present in a firm but loving manner, and not allow himself to be emotionally gotten rid of. If the father overreacts, he may need a reaffirmation of his own masculinity so he will not treat the little boy as if he were a real rival. The mother generally does best to support the father in these situations, or at least not interfere. She needs to become aware of and temper any seductiveness on her part. If she disagrees with her husband's

approach, it is best they resolve the differences out of earshot of the child.

The physician's support of the resilient parental coalition can help avoid its being split through irreconcilable disagreements over the child or through competition to be the favored parent in the eyes of the child. Preservation of the parental coalition makes it easier for the boy to relinquish aspects of his love attachment to his mother and to identify with a firm and loving father figure. The strengthening and gradual internalization of identification with the same gender parent is believed by many to increase the chances of the individual's eventual sexual preference being of a heterosexual nature.¹⁷

Single parents, in particular, often need someone, such as a caring doctor, to help them relinquish the child's excessive love attachment to them. Physicians have the opportunity, themselves or through referral, to help parents improve their functioning, which can contribute to a healthier marriage in addition to helping their children.

Summary

The physician who has contact with the family, working with the child and/or with the parents, has the opportunity to influence the family system so as to facilitate the child's development of a normal gender identity, gender role, and sexual self.

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WHY SHOULD YOU REFER CHILDREN AND ADOLESCENTS WITH SPINA BIFIDA TO CUMBERLAND HOSPITAL?

Cumberland Specializes in Child and Adolescent Care

Each year, some 200 pediatric patients ages 2-22 needing rehabilitation and behavior management are admitted to Cumberland Hospital for Children and Adolescents. While many hospitals provide excellent medical treatment, Cumberland adapts its programs to meet the social and psychological needs of young people.

Treatment is often incorporated into traditional adolescent activities. For example, treatment may include a basketball or volleyball game played in the gymnasium or the swimming pool. Individual mobility goals may be tested and explored during an outing to one of the local parks such as Busch Gardens (amusement park), Jamestown, Yorktown or Williamsburg.

For the young person with spina bifida, there is always a new challenge and a new opportunity to stretch his or her abilities and confidence.

Functional Mobility and Independence

The most visible and often most emotionally charged issue for the young person with spina bifida is mobility. Almost all children with spina bifida wear orthoses, and many use wheelchairs. Ambulatory skills are often achieved late and tend to reach a maximum in the 5- to 8-year-old age group.

With the approach of adolescence, there are increases in weight and height that make ambulation more difficult and less cosmetic.



Difficult decisions must be made regarding the young person's future. Cumberland assists patients and their parents in determining the form of mobility that is most acceptable to them, and help them structure their lives accordingly.

Adolescence is also a time when all young people begin to become independent, and independence for the young person with spina bifida means they take responsibility for their bowel and bladder program and for donning and doffing their braces.

Cumberland evaluates the gross and fine motor skills of the patients as well as their level of intellectual functioning. This information is needed to assist patients and their parents in setting reasonable expectations. Behavior and therapy programs are structured around these expectations.

Cumberland Is A Hospital

Cumberland is licensed by the Commonwealth of Virginia and accredited by the Joint Commission on Accreditation of Healthcare Organizations. It is one of only a few hospitals in the United States where all the physicians on the admitting staff are Board Certified in their specialty.



Cumberland Doesn't Look Like a Hospital

The hospital looks more like a small college with buildings connected by sidewalks, and picnic tables and recreation facilities are disbursed among the facilities. It is common to see young people in small groups talking, studying or

listening to music. Throughout the day, they go between the dormitory, cafeteria, rehabilitation, school and other buildings.

Depending on their level of physical abilities and behavior program, the young people are given levels of independence on the campus ranging from strict one-on-one staff supervision to free movement within the immediate environment.

Young People At Cumberland Go To School

One of the most important elements in the life of a young person is school, and at Cumberland patients go to school. Integrated into the hospital campus is Cumberland Academy—a licensed private school. The building includes classrooms, a library, prevocational department and gymnasium.

Course work is obtained from each patient's home school and classes are conducted around treatment and rehabilitation programs.

Cumberland Serves Many Different Young People

Cumberland provides treatment for young people with many types of medical and behavioral problems, and this has proved to be very beneficial for the patients with spina bifida. While there are usually a number of young people in the hospital with spina bifida, there are also patients with brain injury, diabetes, seizure disorders, spinal cord injuries, asthma and other conditions.

The young people quickly develop friendships and learn about the "disabilities and abilities" of the other young people. They leave the hospital with their medical needs treated and better able to cope with problems and challenges they encounter.

Cumberland's Setting

Cumberland is located on the Pamunkey River and is part of 1,200 acres owned by the hospital. There are three large lakes on the property for fishing and boating, and miles of trails.

For more information on Cumberland Hospital or to refer a patient for treatment, please call the information office at 1-800-368-3472.

**Cumberland Hospital
for Children and Adolescents**
New Kent, Virginia

Journey of the Maryland International Health Task Force to post-war Kuwait: May 19–27, 1991

The Kuwait 38

Thirty-eight physicians, nurses, hospital administrators, and support personnel—members of the Maryland Medical Task Force—journeyed to Kuwait in May 1991. The experience sensitized members of the Maryland delegation to the specific needs of post-war Kuwait in rebuilding its health care system.

Kuwait is a tiny country, slightly smaller than the state of New Jersey (Figure 1), located in the northeast Arabian peninsula on a gradually sloping plain rising westward from the Persian Gulf. It is a country of riverless desert with few oases and almost no arable land. Settled by the Anaiza tribe in the eighteenth century, the country has been ruled by an emir of the Al-Sabah family since 1751. Kuwait was a province within the Ottoman Empire from the sixteenth century until 1899, when the Emir signed a treaty making it a British protectorate; in 1961, Kuwait achieved independence. Prior to the Iraqi invasion of August 2, 1990, Kuwait had a population of approximately 2.1 million, of which only a quarter were Kuwaiti citizens. Approximately 85 percent of Kuwait's pre-war population lived in Kuwait City.

Origin of the Maryland Task Force

In a meeting with the Kuwaiti ambassador on February 13, 1991, Governor William Donald Schaefer offered Maryland business and humanitarian resources to the government of Kuwait for the rebuilding of the war-torn country. On March 5, 1991, Governor Schaefer and the Kuwait/Maryland Partnership announced specific plans for initiating such assistance. The governor's intention was for the business community, through its Kuwait/Maryland Partnership, to work with an International Health Task Force to deliver humanitarian aid. This was to be followed by efforts to develop long-term business contracts. The Maryland International



Figure 1. Kuwait.

Health Task Force evolved as an integral element of this general plan. "The Kuwait 38," as this task force came to be known, consisting of doctors, nurses, hospital administrators, and various support personnel (**Figure 2**), was to be the vanguard of the governor's humanitarian initiatives. It came to life as a result of the work of the secretary of the Maryland International Division; Maryland's Secretary of Health Nelson Sabatini; James A. D'Orta, M.D., an emergency physician and disaster planning specialist; and other members of the Kuwait/Maryland Partnership.

Journey to Kuwait City

The Kuwait 38 assembled at Franklin Square Hospital on May 19, 1991. (The funds to cover travel expenses came from

a variety of sources including the government of Kuwait, the US pharmaceutical industry, and Northwest Orient Airlines.) After a formal farewell from the governor and other dignitaries, the group traveled by bus to Kennedy airport and then to Dharan, Saudi Arabia, via a chartered 747 aircraft being sent to Saudi Arabia to transport US troops returning from Operation Desert Storm. We arrived in darkness at the air force base in Dharan on May 20 and were promptly met by US officials concerned with expediting our travel into Kuwait. Following a day's layover in Dharan because Kuwait was not ready to receive our delegation at the time of our arrival, arrangements were made to bus us overland through the Saudi Arabian desert to Kuwait City. The six-hour journey, which carried us due north over a narrow two-lane highway, was negotiated in one of only a few small caravans proceeding in that direction.

As we approached Saudi Arabia's northern frontier, we encountered Khafji, the site of Iraq's only offensive action during Operation Desert Storm. Images of the struggle for control of the town by Iraqi and coalition troops lingered among the rubble of the battle fought there. At the time of our arrival, widespread damage to many buildings left little doubt that fierce house-to-house fighting had occurred during liberation of the town by coalition forces.

We continued north for another hour, finally reaching the Kuwaiti border. On the way, we passed a continuous succession of convoys of military matériel proceeding south to Dharan and demobilization. Inverted Vs hastily painted on the sides of the vehicles identified them as coalition vehicles and conjured up memories of editorials on the role of friendly fire as a source of casualties in modern warfare.

Although our group arrived at the Kuwaiti border in the early afternoon, the day had aged prematurely owing to an effluvium of oil and dust (**Figure 3**), originating from the burning Al Ahmadi oil fields to the north and west of Kuwait City and a seasonal sand-



Figure 2. The Kuwait 38.



Figure 3. Haze over Kuwait resulting from the combined effects of Kuwait's burning oil fields and a seasonal sandstorm.

storm indigenous to the area. Two hours at the border for processing visas, and we proceeded north again to Kuwait City. Our first impression on entering the capital city of Kuwait was the juxtaposition of emptiness and grandeur. Boulevard upon boulevard of battered and deserted high-rise buildings faded sullenly from view as we slowly made our way to our final destination at the Al-Sabah Hospital complex. There we were to spend the next five days observing firsthand the results of Iraq's ten-month reign of terror.

Observations

Prior to the invasion, Kuwait boasted a medical care system as sophisticated as any in the world. Anyone requiring medical care received it, free of charge, at any of Kuwait's five specialty hospitals or associated clinics. In the rare instances where these modern and well-equipped facilities could not provide particular medical services, patients were transported to appropriate facilities outside the country. For Kuwaiti citizens, all expenses related to such care were defrayed by the government.

The Kuwaiti health care and medical education systems were patterned after the British model, with various specialty and general hospitals supported by a network of area referral centers located throughout the country. Because medicine has not traditionally been a particularly prestigious profession, compared with commerce, relatively few native Kuwaitis have chosen to become physicians. Like nurses and other support personnel who staffed the medical facilities prior to the invasion, physicians working in Kuwait were largely foreign nationals.

The hospitals of pre-invasion Kuwait were spacious, well-equipped, and efficient. There was a general hospital (Al-Sabah); a hospital devoted to pediatrics, neurosurgery, and ophthalmology (Ibn Sina); a burn, plastic surgery, and orthopaedic hospital (Al Razi); as well as a chest hospital, organ transplant center, cancer center, and maternity hospital. All of these facilities served a total population of little more than two million people.

As noted previously, physicians working in Kuwait were largely recruited outside the country. Most came from neighboring countries such as Egypt, Iraq, Jordan, and Syria. Others came from Pakistan and India. Physicians from communist block countries also came in large numbers to work in Kuwaiti hospitals.

There was a single medical school, which graduated approximately forty Kuwaiti nationals per year. Women accounted for over half of the Kuwaiti graduates. Since women in Kuwait have a lower social status than men, although a higher status than women in most other Persian Gulf countries, the high percentage of female medical graduates again reflects the relatively low level of esteem accorded the medical profession in traditional Kuwaiti society.

As a result of the invasion, Kuwait and its medical community suffered massive devastation. The following

The Kuwait 38

- | | |
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vignettes illustrate the enormity of such devastation. Although they focus mainly on destruction of Kuwaiti property by Iraqi soldiers, in all probability, the social and psychological trauma related to the invasion will be the most crushing legacy of Iraq's aggression to the south.

As a direct consequence of the invasion, medical personnel in Kuwait shrank to one-third the normal complement of doctors and 10 percent of the normal nursing force. Much medical equipment was stolen or vandalized. Fortunately, the Kuwaitis managed to save many items by duping the Iraqis into taking or destroying old rather than new equipment—the new equipment having been hidden in false ceilings and other secret storage places. As a result, at the time of our visit, the three operating hospitals contained equipment comparable to that available in most US hospitals.

Saving such equipment from Iraqi hands involved no small measure of courage on the part of the Kuwaitis. The story of the head clerk of the storeroom at the Al-Razi Hospital typifies such bravery. Shortly after arriving in Kuwait City, the Iraqis deployed large numbers of soldiers in each of the city's hospitals. At the Al-Razi Hospital, a contingent of such soldiers were billeted in the hospital's store room. The clerk, anticipating the worst, hid much of the hospital's most expensive equipment in the store room's false ceiling just prior to the arrival of Iraqi soldiers. The penalty for his actions, if discovered, would have been death.

Kuwait's Transplant Center, the jewel in the crown of the country's hospital complex, became the headquarters for Iraqi troops stationed at the Al-Sabah Hospital Complex. Kidney, heart, liver, and pancreas transplants were performed at this new facility prior to the invasion. Kidney transplants were

one of its most important functions, because of the estimated 12 percent rate of chronic renal failure among the adult male population of Kuwait.

Because of the symbolic and material importance of the Transplant Center to the people of Kuwait, the Iraqis were particularly harsh in acts of vandalism directed at the facility. Operating rooms, as modern and beautifully equipped as any in Maryland, were systematically dismantled. The destruction was efficient, comprehensive, and senseless.

The Iraqis met almost no organized military resistance in taking Kuwait City. Furthermore, little, if any, fighting took place in the city during their withdrawal. Yet large areas of the city looked as if they had been under heavy bombardment for months (**Figure 4**). Such devastation was due to the work of Iraqi sappers or the result of gratuitous Iraqi artillery fire directed at civilian targets during the final days of occupation.

One of the more bizarre acts of vandalism by Iraqi forces was the pilfering of automotive tires and parts. We were told by several contacts that each tire had the equivalent worth of a month's salary for the average Iraqi soldier. During the occupation, the Iraqis established a complicated hierarchy concerned with confiscating rights to Kuwaiti tires. The tires from Mercedes Benz vehicles went to the highest ranking officers; lower ranking officers had rights to tires from Saabs and Volvos; the very lowest ranking soldiers had access only to bicycle tires.

During the occupation, the Kuwait Medical School suffered a fate similar to the country's hospitals. Faculty from the University of Baghdad came to Kuwait City on the heels of the invasion to supervise the systematic dismantling and plundering of Kuwait's university and medical school. As

one Kuwaiti professor described it, you could walk down the hall and find chemistry equipment with a Baghdad University label and another piece of equipment labeled for transport to some other Iraqi university. Inexplicably, the microbiology laboratory equipment was slated for transport to the presidential palace in Baghdad. The wholesale plundering of Kuwait's assets included the entire medical school library, as well as personal literary collections of the Kuwaiti medical faculty. Iraq also attempted to coerce many Kuwaiti faculty into moving north to teach in Iraqi universities but were rarely successful.



Figure 4. Destruction of Kuwait's telecommunications building by retreating Iraqi forces.

Accomplishments

One of Governor Schaefer's original mandates for the Maryland Medical Task Force was to provide hands-on clinical assistance in post-war Kuwait. Our accomplishments in this regard were, at best, modest. Members of the task force participated in clinical rounds with local physicians immediately upon arrival and continued these rounds throughout the five-day stay. Although there were few opportunities for our party to function as primary caregivers, there were several gratifying exceptions to our role as consultants and interested observers.

Soon after our arrival, our emergency medicine physicians and plastic surgeons attempted, unsuccessfully, to resuscitate a young boy with massive explosion injuries. Shortly thereafter, we observed and participated in the care of a child recovering from a shrapnel-induced spinal injury, another with massive facial and ophthalmologic injuries, as well as children and adults with major burns and amputations. We participated in the care of a septic 2-year-old child requiring an emergency laparotomy and colostomy revision. One of our surgeons successfully performed a pulmonary lobectomy on an elderly man with recurrent pneumothorax. Two of our plastic surgeons evaluated and treated an American fire fighter severely burned while attempting to extinguish one of the 400 oil fires still raging in Kuwait (Figure 5). The surgeons eventually coordinated the fire fighter's transfer back to the United States. Both our plastic and orthopaedic surgeons were consulted repeatedly by their Kuwaiti counterparts during the visit.

Transportation of several complicated cases to Maryland medical institutions was arranged by our team. These patients included an infant with bladder exstrophy, a young child with a congenital mid-facial cleft, a pregnant woman with disfiguring chest and abdominal burn scars, and a middle-aged man with severe cardiac valvular disease. Despite the sophisticated level of medical care in pre-war Kuwait, resources required to treat such patients were unavailable in the country at the time of our visit.

Humanitarian and educational aid to Kuwait resulting from our visit continues in various forms. Dr. Najeeb Al-Othman, the director of the pediatric intensive care unit (ICU) at Ibn Sina Hospital, will visit the Johns Hopkins Hospital as an observer in the pediatric ICU and in the Regional Pediatric



Figure 5. Burning wells in Kuwait's Al Ahmadi oil field.

Trauma Center. The Maryland Institute for Emergency Medical Services Systems (MIEMSS) has extended invitations to Kuwaiti colleagues to visit Maryland as fellows or observers in adult trauma care. The institute is also working to establish long-range cooperative initiatives concerned with constructing an appropriate national trauma program in Kuwait.

Aftermath

The question lingering in the minds of participants as well as those who watched the mission to Kuwait unfold is whether the visit by members of the Kuwait 38 in May of 1991 was a success. It would be difficult, even if we had had focused goals and objectives, which we did not, to ascertain the impact of any such health care initiative. The final effects of the mission on the relationship between Maryland and Kuwait will take years to realize.

Nevertheless, several cooperative ventures have already developed between Maryland organizations and Kuwait that augur well for future productive liaisons. In August, on the first anniversary of the invasion, Dr. Abdullah Al Hamadi, the assistant director of the Ibn Sina Hospital in Kuwait, presented testimony to a subcommittee of Congress pertaining to atrocities committed by Iraq during the occupation. During his visit to the United States, Dr. Al Hamadi toured the University of Maryland and the Johns Hopkins Medical Centers, exploring opportunities first raised by the Maryland delegation in Kuwait for postgraduate education in Baltimore. Through such efforts, it is hoped that Maryland will have a pivotal role in training the future leaders of Kuwait medicine.

In May 1991, Kuwait's Ministry of Education invited several members of the Kuwait 38 to return to his country in

August 1991 to present an in-depth program of stress debriefing. This follow-up mission involved twelve days of intense didactic and group education initiatives presented to Kuwait's leaders in education. The success of this endeavor was reflected by the fact that the Ministry of Education exerted considerable pressure on the team to remain in Kuwait for ten days longer than originally planned. In addition, representatives from Kuwait's Ministry of Education and various school districts in Kuwait visited Baltimore in November 1991 for two weeks of intensive training in stress-debriefing techniques.

During the original mission, several prominent Kuwaiti health officials expressed keen interest in the system of trauma management operating at the MIEMSS Shock Trauma Center. The current director of Kuwait's emergency medicine system, who received his masters in public health from the Johns Hopkins School of Hygiene and Public Health, will visit the Shock Trauma Center, the Department of Emergency Medicine at the University of Maryland Medical Center, and the Franklin Square Hospital Center in the near future. One purpose of his visit is to explore the possibility of developing similar programs in Kuwait.

Preliminary meetings have taken place between various members of the Kuwait 38 and representatives from the Kuwait Institute for Medical Specialization (KIMS) and the Ministry of Higher Education, whose responsibility will be to select new leadership concerned with reopening Kuwait's devastated medical school. Such meetings have explored ways in which Maryland's two medical schools might participate in the reconstruction of Kuwait's medical school.

The future

The journey of the Maryland Medical Task Force to Kuwait in May 1991 brought together representatives from health care systems in Kuwait and Maryland. It sensitized members of the Maryland delegation to the specific needs of post-war Kuwait in rebuilding its health care system. At the same time, Kuwaiti officials involved in that process learned of the commitment and capabilities of several Maryland institutions to assist with the task. Time will determine whether initiatives first conceived as a result of our trip will enable Maryland to participate in a meaningful way in the resurrection of Kuwaiti medicine and the development of the future leaders of that country's health care system. ■

Update on health status in Kuwait

James P.G. Flynn, M.D., M.P.H.

Dr. Flynn is director of Corporate Rehabilitation Services, University of Maryland Medical System, and former director, Maryland Institute for Emergency Medical Services Systems.

I was invited by representatives of the Ministry of Education and the Ministry of Public Health to return to Kuwait with a team of social workers, psychologists, and counselors in August 1991. A number of positive changes had occurred during the intervening three months. The return or recruitment of physicians and other members of the health care delivery team was evident, particularly in hospital clinical programs. Also, the leaders of the emergency medical services programs were replacing equipment stolen or vandalized during the occupation. A public awareness effort using visual, radio, and print media was underway to alert adults and children to the hazards of handling nondetonated ordnance. This campaign was most successful, since serious injuries among children, caused by explosion of these devices had been virtually eliminated.

Electricity and water had become increasingly available, and sewage disposal had improved. Pollution had diminished secondary to the capping of burning oil wells.

The emphasis on somatic conditions, apparent during our mission in May, had shifted to greater interest in the psychosocial condition and mental health status of the community. This was reflected in the Kuwaiti's enthusiastic acceptance of training initiatives conducted by other members of the Maryland team in the recognition, management, and prevention of these stress reactions. The country's healing was interrupted by a resurgence of anxiety caused by the Iraqi government's aggressive support of the abortive coup in the Soviet Union.

Physicians, social workers, psychologists, and educators from Kuwait came to the University of Maryland Medical Center on three occasions to interact with leadership staff and reinforce relationships established earlier in the year. It is anticipated that these interactions will continue to be mutually productive. ■

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INDICATIONS AND USAGE

ACCUPRIL is indicated for the treatment of hypertension. It may be used alone or in combination with thiazide diuretics.

In using ACCUPRIL, consideration should be given to the fact that another angiotensin-converting enzyme (ACE) inhibitor, captopril, has caused agranulocytosis, particularly in patients with renal impairment or collagen vascular disease. Available data are insufficient to show that ACCUPRIL does not have a similar risk (see WARNINGS).

CONTRAINDICATIONS

ACCUPRIL is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

WARNINGS

Angioedema: Angioedema of the face, extremities, lips, tongue, glottis, and larynx has been reported in patients treated with ACE inhibitors and has been seen in 0.1% of patients receiving ACCUPRIL. Angioedema associated with laryngeal edema can be fatal. If laryngeal stridor or angioedema of the face, tongue, or glottis occurs, treatment with ACCUPRIL should be discontinued immediately, the patient treated in accordance with accepted medical care, and carefully observed until the swelling disappears. In instances where swelling is confined to the face and lips, the condition generally resolves without treatment; antihistamines may be useful in relieving symptoms.

Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, emergency therapy including, but not limited to, subcutaneous epinephrine solution 1:1000 (0.3 to 0.5 mL) should be promptly administered (see ADVERSE REACTIONS).

Hypotension: Symptomatic hypotension was rarely seen in uncomplicated hypertensive patients treated with ACCUPRIL but, as with other ACE inhibitors, it is a possible consequence of therapy in salt/volume depleted patients, such as those previously treated with diuretics or dietary salt restriction or who are on dialysis (see PRECAUTIONS, DRUG INTERACTIONS, and ADVERSE REACTIONS). In controlled studies, syncope was observed in 0.4% of patients (N = 3203); this incidence was similar to that observed for captopril (1%) and enalapril (0.8%).

In patients with concomitant congestive heart failure, with or without associated renal insufficiency, ACE inhibitor therapy may cause excessive hypotension, which may be associated with oliguria or azotemia and, rarely, with acute renal failure and death. In such patients, ACCUPRIL therapy should be started at the recommended dose under close medical supervision. These patients should be followed closely for the first 2 weeks of treatment and whenever the dosage of antihypertensive medication is increased (see DOSAGE AND ADMINISTRATION).

If symptomatic hypotension occurs, the patient should be placed in the supine position and, if necessary, normal saline may be administered intravenously. A transient hypotensive response is not a contraindication to further doses; however, lower doses of ACCUPRIL or reduced concomitant diuretic therapy should be considered.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression rarely in patients with uncomplicated hypertension, but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease such as systemic lupus erythematosus or scleroderma. Agranulocytosis did occur during ACCUPRIL treatment in one patient with a history of neutropenia during previous captopril therapy. Available data from clinical trials of ACCUPRIL are insufficient to show that, in patients without prior reactions to other ACE inhibitors, ACCUPRIL does not cause agranulocytosis at similar rates. As with other ACE inhibitors, periodic monitoring of white blood cell counts in patients with collagen vascular disease and/or renal disease should be considered.

Fetal/Neonatal morbidity and mortality: ACE inhibitors, including ACCUPRIL, can cause fetal and neonatal morbidity and mortality when administered to pregnant women.

When ACE inhibitors have been used during the second and third trimesters of pregnancy, there have been reports of hypotension, renal failure, skull hypoplasia, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios has been associated with fetal limb contractures, craniofacial deformities, hypoplastic lung development, and intrauterine growth retardation.

Prematurity and patent ductus arteriosus have been reported, although it is not clear whether these occurrences were due to the ACE-inhibitor exposure or to the mother's underlying disease. It is not known whether exposure limited to the first trimester can adversely affect fetal outcome.

A patient who becomes pregnant while taking ACE inhibitors, or who takes ACE inhibitors when already pregnant, should be apprised of the potential hazard to her fetus. If she continues to receive ACE inhibitors during the second or third trimester of pregnancy, frequent ultrasound examinations should be performed to look for oligohydramnios. When oligohydramnios is found, ACE inhibitors should generally be discontinued.

Infants with histories of in utero exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Hemodialysis and peritoneal dialysis have little effect on the elimination of quinapril and quinaprilat.

No fetotoxic or teratogenic effects were observed in rats at quinapril doses as high as 300 mg/kg/day (180 and 30 times the maximum daily human dose when based on mg/kg and mg/m², respectively), despite maternal toxicity at 150 mg/kg/day. Tested later in gestation and during lactation, reduced offspring body weight was seen at ~25 mg/kg/day, and changes in renal histology (juxtaglomerular cell hypertrophy, tubular/pelvic dilation, glomerulosclerosis) were observed both in dams and offspring treated with 150 mg/kg/day. Quinapril was not teratogenic in the rabbit; however, as noted with other ACE inhibitors, maternal toxicity and embryotoxicity were seen in some rabbits at quinapril doses as low as 0.5 mg/kg/day (one time the recommended human dose) and 1.0 mg/kg/day, respectively.

PRECAUTIONS

General

Impaired renal function: As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including ACCUPRIL, may be associated with oliguria and/or progressive azotemia and rarely acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine have been observed in some patients following ACE inhibitor therapy. These increases were almost always reversible upon discontinuation of the ACE inhibitor and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some hypertensive patients with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when ACCUPRIL has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of any diuretic and/or ACCUPRIL may be required.

Evaluation of hypertensive patients should always include assessment of renal function (see DOSAGE AND ADMINISTRATION).

Hyperkalemia and potassium-sparing diuretics: In clinical trials, hyperkalemia (serum potassium >5.5 mmol/L) occurred in approximately 2% of patients receiving ACCUPRIL. In most cases, elevated serum potassium levels were isolated values which resolved despite continued therapy. Less than 0.1% of patients discontinued therapy due to hyperkalemia. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with ACCUPRIL (see PRECAUTIONS, Drug Interactions).

Surgery/anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, ACCUPRIL will block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients

Angioedema: Angioedema, including laryngeal edema, can occur with treatment with ACE inhibitors, especially following the first dose. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to stop taking the drug until they have consulted with their physician (see WARNINGS).

Symptomatic hypotension: Patients should be cautioned that lightheadedness can occur, especially during the first few days of ACCUPRIL therapy, and that it should be reported to a physician. If actual syncope occurs, patients should be told to not take the drug until they have consulted with their physician (see WARNINGS).

All patients should be cautioned that inadequate fluid intake or excessive perspiration, diarrhea, or vomiting can lead to an excessive fall in blood pressure because of reduction in fluid volume, with the same consequences of lightheadedness and possible syncope.

Patients planning to undergo any surgery and/or anesthesia should be told to inform their physician that they are taking an ACE inhibitor.

Hyperkalemia: Patients should be told not to use potassium supplements or salt substitutes containing potassium without consulting their physician (see PRECAUTIONS).

Accupril® (Quinapril Hydrochloride Tablets)

Neutropenia: Patients should be told to report promptly any indication of infection (eg, sore throat, fever) which could be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with ACCUPRIL is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions

Concomitant diuretic therapy: As with other ACE inhibitors, patients on diuretics, especially those on recently instituted diuretic therapy, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with ACCUPRIL. The possibility of hypotensive effects with ACCUPRIL may be minimized by either discontinuing the diuretic or cautiously increasing salt intake prior to initiation of treatment with ACCUPRIL. If it is not possible to discontinue the diuretic, the starting dose of quinapril should be reduced (see DOSAGE AND ADMINISTRATION).

Agents increasing serum potassium: Quinapril can attenuate potassium loss caused by thiazide diuretics and increase serum potassium when used alone. If concomitant therapy of ACCUPRIL with potassium-sparing diuretics (eg, spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes is indicated, they should be used with caution along with appropriate monitoring of serum potassium (see PRECAUTIONS).

Tetracycline and other drugs that interact with magnesium: Simultaneous administration of tetracycline with ACCUPRIL reduced the absorption of tetracycline by approximately 28% to 37%, possibly due to the high magnesium content in ACCUPRIL tablets. This interaction should be considered if coprescribing ACCUPRIL and tetracycline or other drugs that interact with magnesium.

Lithium: Increased serum lithium levels and symptoms of lithium toxicity have been reported in patients receiving concomitant lithium and ACE inhibitor therapy. These drugs should be co-administered with caution, and frequent monitoring of serum lithium levels is recommended. If a diuretic is also used, it may increase the risk of lithium toxicity.

Other agents: Drug interaction studies of ACCUPRIL with other agents showed:

- Multiple dose therapy with propranolol or cimetidine has no effect on the pharmacokinetics of single doses of ACCUPRIL.
- The anticoagulant effect of a single dose of warfarin (measured by prothrombin time) was not significantly changed by quinapril coadministration twice-daily.
- ACCUPRIL treatment did not affect the pharmacokinetics of digoxin.
- No pharmacokinetic interaction was observed when single doses of ACCUPRIL and hydrochlorothiazide were administered concomitantly.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Quinapril hydrochloride was not carcinogenic in mice or rats when given in doses up to 75 or 100 mg/kg/day (50 to 60 times the maximum human daily dose, respectively, on a mg/kg basis and 3.8 to 10 times the maximum human daily dose when based on a mg/m² basis) for 104 weeks. Female rats given the highest dose level had an increased incidence of mesenteric lymph node hemangiomas and skin/subcutaneous lipomas. Neither quinapril nor quinaprilat were mutagenic in the Ames bacterial assay with or without metabolic activation. Quinapril was also negative in the following genetic toxicology studies: *in vitro* mammalian cell point mutation, sister chromatid exchange in cultured mammalian cells, micronucleus test with mice, *in vitro* chromosome aberration with V79 chromated lung cells, and in an *in vivo* cytogenetic study with rat bone marrow. There were no adverse effects on fertility or reproduction in rats at doses up to 100 mg/kg/day (60 and 10 times the maximum daily human dose when based on mg/kg and mg/m², respectively).

Pregnancy

Pregnancy Category D: See WARNINGS, Fetal/Neonatal morbidity and mortality.

Nursing Mothers

It is not known if quinapril or its metabolites are secreted in human milk. Quinapril is secreted to a limited extent, however, in milk of lactating rats (5% or less of the plasma drug concentration was found in rat milk). Because many drugs are secreted in human milk, caution should be exercised when ACCUPRIL is given to a nursing mother.

Geriatric Use

Elderly patients exhibited increased area under the plasma concentration time curve (AUC) and peak levels for quinapril compared to values observed in younger patients; this appeared to relate to decreased renal function rather than to age itself. In controlled and uncontrolled studies of ACCUPRIL where 918 (21%) patients were 65 years and older, no overall differences in effectiveness or safety were observed between older and younger patients. However, greater sensitivity of some older individual patients cannot be ruled out.

Pediatric Use
The safety and effectiveness of ACCUPRIL in children have not been established.

ADVERSE REACTIONS

ACCUPRIL has been evaluated for safety in 4960 subjects and patients. Of these, 3203 patients, including 655 elderly patients, participated in controlled clinical trials. ACCUPRIL has been evaluated for long-term safety in over 1400 patients treated for 1 year or more.

Adverse experiences were usually mild and transient.

Discontinuation of therapy because of adverse events was required in 4.7% of patients treated with ACCUPRIL in placebo-controlled hypertension trials.

Adverse experiences probably or possibly related to therapy or of unknown relationship to therapy occurring in 1% or more of the 1563 patients in placebo-controlled hypertension trials who were treated with ACCUPRIL are shown below.

Adverse Events in Placebo-Controlled Trials

	ACCUPRIL (N = 1563) Incidence (Discontinuation)	Placebo (N = 579) Incidence (Discontinuation)
Headache	5.6 (0.7)	10.9 (0.7)
Dizziness	3.9 (0.8)	2.6 (0.2)
Fatigue	2.6 (0.3)	1.0
Coughing	2.0 (0.5)	0.0
Nausea/Vomiting	1.4 (0.3)	1.9 (0.2)
Abdominal Pain	1.0 (0.2)	0.7

Clinical adverse experiences probably or possibly related, or of uncertain relationship to therapy, occurring in 0.5% to 1.0% (except as noted) of the patients treated with ACCUPRIL (with or without concomitant diuretic) in controlled or uncontrolled trials (N = 4397) and less frequent, clinically significant events seen in clinical trials or post-marketing experience (the rarer events are in italics) include (listed by body system):

General: back pain, malaise

Cardiovascular: palpitation, vasodilation, tachycardia, heart failure, hyperkalemia, myocardial infarction, cerebrovascular accident, hypertensive crisis, angina pectoris, orthostatic hypotension, cardiac rhythm disturbances

Gastrointestinal: dry mouth or throat, constipation, gastrointestinal hemorrhage, pancreatitis, abnormal liver function tests

Nervous/Psychiatric: somnolence, vertigo, syncope, nervousness, depression

Integumentary: increased sweating, pruritus, exfoliative dermatitis, photosensitivity reaction

Urogenital: acute renal failure

Other: amblyopia, pharyngitis, sinusitis, bronchitis, agranulocytosis, thrombocytopenia

Angioedema: angioedema has been reported in patients receiving ACCUPRIL (0.1%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with ACCUPRIL should be discontinued and appropriate therapy instituted immediately. (see WARNINGS.)

Clinical Laboratory Test Findings

Hematology: (See WARNINGS)

Hyperkalemia: (See PRECAUTIONS)

Creatinine and blood urea nitrogen: Increases (>1.25 times the upper limit of normal) in serum creatinine and blood urea nitrogen were observed in 2% and 2%, respectively, of patients treated with ACCUPRIL alone. Increases are more likely to occur in patients receiving concomitant diuretic therapy than in those on ACCUPRIL alone. These increases often remit on continued therapy.

* In some patients, the antihypertensive effect may diminish toward the end of the once-daily dosing interval. In such patients, an increase in dosage or twice-daily administration may be warranted.



Division of Warner-Lambert Company
Morris Plains, New Jersey 07950

James McHenry, M.D. of Fort McHenry in Baltimore Towne

Joseph M. Miller, M.D.

Dr. Miller is a retired surgeon from Timonium.

James McHenry, M.D., whose name is best known for the fort immortalized in the Star Spangled Banner, was one of the early members of Med Chi. In addition, he was secretary to George Washington; aide to Lafayette; member of the Maryland Senate, the General Assembly of Maryland, and the US Congress; and signer of the Constitution.

The recent observation of the bicentennial of the Constitution also commemorated the men who were involved in the creation of a strong central government. For twenty-two of the thirty-nine signers, their experiences as veterans of the Revolutionary War made them more than conscious of the necessity of safeguarding the individual liberties for which they had fought. The group were patriots and leaders by any definition; they fought the war, created and signed the Constitution, and forged a different kind of government. One of these men lived in Maryland and is truly representative of the entire group.

Fort McHenry was immortalized by Francis Scott Key when he wrote the words to the *Star Spangled Banner* during the night and early morning of September 13–14, 1814. Although the people of Maryland recognize the name of the fort, few know about the intriguing individual who gave his name to the site.

James McHenry, born in Ireland in 1753, was sent to Dublin by his parents and received a classical education.¹⁻⁵ He sailed for the colonies in 1771.

Early on, he was in the care of Captain William Allison in Philadelphia whose stepdaughter, Margaret Caldwell, he subsequently married. McHenry was so enamored with life in the colonies that he persuaded his parents, who brought along a younger brother, to emigrate to America in 1772. In the following year, the father, in company with his son John, established a business in Baltimore.

McHenry went to the Academy in Newark, Delaware in 1772, and then to Philadelphia to study medicine with Dr. Benjamin Rush. The budding medical student was enrolled with Rush when the momentous political events preceding the Revolution occurred. Two sessions of the General Congress made Philadelphia a remarkable place for studies beside medicine. Inasmuch as Rush knew George Washington very well, reason suggests that he may have introduced McHenry to the future president with whom McHenry later formed a firm friendship.

The patriotic Dr. McHenry settled his affairs in Philadelphia after the

war started and in January 1776, volunteered for the army as an assistant surgeon at the American Hospital in Cambridge. He was not yet an officer but his work had to be more than acceptable, for on August 26, 1776, Congress passed the following resolution: "Resolved that Congress have a proper sense of the merit and services of Doctor McHenry, and recommended it to the Directors of the different hospitals belonging to the United States to appoint Doctor McHenry to the first vacancy that shall happen of surgeon's birth (sic) in any of the said hospitals." On August 10, McHenry became surgeon to the Fifth Pennsylvania Battalion stationed at Fort Washington.

When that site was attacked and taken by the British on November 16, McHenry, four other surgeons, and 2,000 men were captured. He was granted a parole on January 27, 1777, and, in that status, reported to Washington on January 31. More than a year elapsed before an exchange was effected because it was not until March 5, 1778 that Alexander Hamilton, then aide-de-camp to the commander-in-chief, wrote McHenry about the announcement.

On May 15, McHenry was made secretary to Washington. He established cordial relations with his chief who later looked upon McHenry as a trusted friend and adviser. He stayed with the Washington family until August 1780, when he became aide-de-camp to Marquis Lafayette. There McHenry remained until he resigned from the army on December 3, 1781 after the surrender of Cornwallis at Yorktown. He was present at the ceremony that marked the last incident in his military life.

Washington might have feared the ardor of the marquis who was given an important command at the age of 23. The commander-in-chief probably took the precaution of giving Lafayette a prudent adviser in the person of McHenry.

McHenry was promoted to major on May 30, 1781, with the date of rank being October 30 of the previous year. The promotion was accomplished through the efforts of General Greene to the commander-in-chief, after Hamilton had failed in an appeal made by General Schuyler.

While still in the army at Yorktown, McHenry was elected to the Maryland Senate. At that time, the legislative body consisted of fifteen members—nine from the western shore and six from the eastern. They were elected for a term of five years by thirty-eight electors chosen by the people in the counties. McHenry held this post until he resigned early in 1786. In 1783, McHenry was also appointed to the US Congress when the incumbent died, and he was then elected to the position later that year. McHenry was returned to office the following year and held the post until 1786. Double duty with the state and the nation was not an uncommon occurrence at that time.

He was a delegate to the Constitutional Convention in Philadelphia in 1787 and also a signer of the Constitution. He participated in the state convention that adopted the Constitution in April 1788. In the autumn of the same year, he was elected to the General Assembly of Maryland and returned there the following year. In 1791, he was sent to the Maryland

Senate and he remained seated there until he became Secretary of War for Washington, a period of almost five years.

Washington had great esteem for McHenry, as evidenced by an extract from a note of January 20, 1796: "that it would now give me sincere pleasure if you will fill the office of Secretary of War." With frank candor, the president told of three previous tenders of office made and refused. Washington added, "nothing would add more to the satisfaction this would give me than your acceptance of the offer." On January 24, McHenry accepted; the nomination was promptly sent to the Senate and unanimously confirmed.

John Adams, the new president in 1797, kept the four incumbent members of the cabinet. Service with Adams, however, was not smooth. Toward the end of Adams' term in office, signs were apparent that he would not be reelected. In addition, his cabinet was not in sympathy with his thoughts. McHenry was a staunch Federalist and maintained his political relationship with Hamilton. Adams falsely charged McHenry, the soul of honesty, with a list of what he thought were transgressions, including a suspicion of intrigue against his reelection as president. A stormy interview followed and McHenry promptly resigned from his position on May 6, 1800 and returned to private life, which he continued until his death in Baltimore in 1816. He was buried in the churchyard of the Westminster Presbyterian Church in Baltimore.

McHenry was a statesman and although lacking experience in the administration of a large military organization, he applied the knowledge gained from his wartime effort as a citizen-soldier to create a disciplined, professional army. His dedication to a strong central government led him to advocate civilian leadership, a concept also held by Washington. This concept of McHenry was challenged, however, by newly appointed generals who attempted to control military appointments and organizational plans for the provisional army. McHenry was convinced that dedicated professional officers were necessary, and this thought led to his proposal for the creation of a military academy. Perhaps the most important service McHenry rendered to his country was his forthright stand against some of these military mights and their political adherents.

Two other episodes in his life are worthy of recall. The naming of the fort and his efforts to establish a military school, now known as West Point, were significant events.

As early as January 30, 1770, the Maryland Congress of Deputies recognized that Baltimore should be fortified if practicable.⁶ Within nine days, a request was forwarded to the Baltimore Committee of Observation to furnish a chart of the North East Branch of the Patapsco River at Whetstone Point. The council lost little time in seeking engineering assistance and on February 2 went to the selected area to learn about the possibility of fortifying the site. A proposal was submitted and approved, and the Baltimore committee agreed to undertake and complete the project for about 6,200 pounds. The sum was provided and work began on February 13.

The initial fortification was apparently limited to a shoreline gun battery to which another group of guns and a

breastwork were added later. The area was then called the Fort at Whetstone Point. During the winter of 1778, the area was equipped with thirty-eight cannon. With the Revolution drawing to a conclusion, however, all but four to five artillery pieces were removed from the fort for use elsewhere.

The fortification at that time was described as an earthen embankment conforming to a five-pointed star surrounded by a ditch. The shore batteries were on lower ground on the tip of Whetstone Point.

After the surrender of Cornwallis, the Baltimore defenses were in an unimproved and neglected condition. On March 20, 1794, congressional legislation was enacted to provide for the defense of certain ports and harbors in the United States. The president was granted authority to proceed with the plan. The Baltimore share of this program was a little over four thousand dollars, a sum intended to erect parapets, embrasures, battery platforms, two magazines, and barracks.

Choosing a site on which to spend this money did not offer a problem. The land at Whetstone Point was provided by an act of the Maryland Legislature and the consent of the local property owners. The appropriation was sufficient to accomplish only a little of the work and a further sum of three thousand dollars was obtained to improve the outer works but not the fort.

During the period of 1798–1800, really significant changes were made because of the fear of a war with France. Another eighty thousand dollars was expended to create an effective defense unit now known as Fort McHenry. A shortfall of thirty thousand dollars was envisioned and the thought of a public subscription was entertained, but Secretary of War McHenry resolved the difficulty by increasing the appropriation to the needed amount. Between 1794 and 1801, almost ninety-four thousand dollars were spent to complete the changes.

The fortification at Whetstone Point had never been the objective of enemy action until 1814. In September of that year, however, Baltimore was able to defend itself nobly at Fort McHenry during the British attack. Being a staunch Federalist, McHenry opposed entering the War of 1812. Interestingly and perhaps slightly ironically, he lived to see his son John follow in his footsteps as a volunteer soldier. John participated in the defense of Fort McHenry against the British forces in 1814.

During the Civil War, Maryland was the site of two prisons for captured Confederate soldiers. In July 1863, after the battle of Gettysburg, over 6,000 prisoners were crammed into Fort McHenry, which ordinarily housed 250–300 persons. Living and hospital conditions were abysmal.

McHenry was also interested in the creation of a military school and on December 26, 1798, Hamilton wrote of having left with General Pinckney thoughts about such a project and inquired of McHenry if he had heard further about the project. In June 1799, McHenry proposed establishment of a military

school to Adams. Later in the same month, the secretary wrote Samuel Sewell, Chairman of Defense, about the academy. McHenry wanted instructors in arithmetic, geometry, mechanics, hydraulics, and designing, for courses needed to prepare artillerymen and engineers for the art of fortification.

Early in January 1800, Adams recommended to Congress the creation of a formal military school, based on the thoughts of Hamilton and McHenry. In March of that year, McHenry asked Hamilton to prepare a bill for this project.

The Medical and Chirurgical Faculty of the State of Maryland was formed in 1799 when McHenry was a resident of Baltimore. He is listed as a member but was not among the 101 incorporators of the faculty. A distinction between a license and membership was not made between 1799 and 1839.

McHenry lived in an area that is now included in downtown Baltimore. The name of his estate was Fayetteville, presumably in honor of the general with whom he served at the end of the war. At that time, the home was south of the Frederick Turnpike and slightly west of Cove Street. Frederick Turnpike is now Baltimore Street and Cove Street has become Freemont Avenue. Orientation on a map of the inner city places the site slightly west of the University of Maryland Hospital.

He spent his summers in Garrett County, of which John W. Garrett and he were cofounders. In 1810, McHenry bought land for his son in Locust Tree Bottom, which included Buffalo Marsh near Hayes. The town of McHenry, named for the doctor, is 11 miles northeast of Oakland on the northern inlet of Deep Creek Lake.

Dr. James McHenry was a remarkable man at any time. As a doctor, prisoner of war, member of the military staff of Washington, and aide to Lafayette, he saw military service for five years. From 1781 to 1800, he occupied positions of trust in the state and nation, and these were climaxed by his activities at the Constitutional Convention and by being Secretary of War for Washington. Truly, McHenry was a man of many parts and one for all seasons.

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TOUGH, SMART AND YOURS

medical
economics

Successfully defending a brain-damaged baby case is the courtroom equivalent of pitching a no-hitter. Because the "sympathy factor" can add millions to a jury's award, many insurance carriers would rather settle than fight.

Not so the P-I-E Mutual Insurance Co. of Cleveland, Ohio, and the 4-year-old law firm—Jacobson, Maynard, Tuschman & Kalur—that does all its defense work. In 21 brain-damaged baby cases it has defended for the doctor-owned company, its record is a remarkable 19-1-1, the last a hung jury. In 1988 it over all scored a total of 31 wins, 3 losses—all malpractice cases.

There's more to those numbers than luck. "Or even legal skill," adds JMT&K founding partner Aaron Jacobson, who was one of Ohio's leading plaintiffs' lawyers before he, Larry E. Rogers, Herbert S. Bell, M.D., and 70 other Cleveland doctors formed P-I-E in 1975.

"It's the concept behind the firm that makes it work. Physician specialty panels review every lawsuit to decide whether the defendant deviated significantly from the standard of care. If he did, we pay. If he didn't, we defend. Makes no difference whether it's a \$5,000 or a \$5 million case. We label it 'No pay.' That policy has resulted in a lot of cases being dropped. Perhaps more important, it's

DON'T YOU WISH THESE DEFENSE LAWYERS WERE YOURS?

This big, multistate firm rarely loses a case. But it's more than luck, or even legal skill, that's behind its enviable record.

By Howard Eisenberg

discouraged the filing of many other cases. Plaintiffs' attorneys have learned that we're fair negotiators when our doctors in the wrong, but won't back down when he's right."

That approach pays off. "According to the most recent report I've seen from the General Accounting Office," says Larry Rogers, P-I-E president and CEO, "in 1984, about 37 percent of medical-malpractice claims were closed without payment. Through 1988, we've closed an average of 75 percent of our cases without a dime changing hands. And it's my understanding that, without including defense costs, St. Paul Fire and Marine Insurance Co.'s 1988 average gross payout for cases closed in Ohio with payment was \$52,500. Our comparable figure was about \$19,000 below

that. That's partly why we can sell an OHG specialty in Ohio—an industrial state that ranks among the most litigious—\$12 million in coverage for just \$26,000."

The unique marriage of P-I-E and JMT&K has been so successful that the carrier has expanded into five other states: Indiana, Kentucky, Maryland, Missouri, and West Virginia. Where P-I-E goes, there goes JMT&K, with some branch offices to date. The firm has 60 trial attorneys, and may well be the nation's largest devoted to the nation's largest medical-malpractice defense.

Could the insurer-defender symbiosis, if duplicated by other doctor companies, make a significant contribution to reducing malpractice litigation nationwide? An up-close look at



how JMT&K operates may help to answer that question.

Every lawyer develops a medical specialty

"Our firm's lawyers read more medical books than law books," says P-I-E Vice President Gerard C. Ogenmuth, himself a veteran defense attorney. Robert Maynard explains, "New cases are discussed at our weekly staff meeting so that every lawyer is familiar with every case. But we assign cases to four attorneys according to medical specialty. They're well-versed in their fields, so they don't have to reinvent the wheel with each case."

Last year, the firm's OHG specialist, attorney Jerome S. Kalur, who had won 16 consecutive brain-damaged baby cases, faced one of his toughest challenges when he defended a GP

who'd attempted a midwifery delivery that ended in a Cesarean section and a severely brain-injured baby. Recalls Kalur, "I didn't think the doctor had caused the damage, but our position was weakened by the fact that he didn't have midwifery privileges. Based on that departure from the standard of care, our doctor panel voted to settle, and, since the hospital was also involved, a combined sum of \$1.5 million was offered. Plaintiffs turned us down flat."

"I wanted to depose the doctor, who'd been involved in the mother's care during her hospitalization, but the attorney for the plaintiff baby insisted it would violate the mother's physician-patient confidentiality. That privilege would terminate automatically when her medical

The winning firm's four founders at Cleveland's 8th District Court of Appeals (from left): Jerome S. Kalur, Aaron Jacobson, James M. Tuschman, and Robert Maynard.

records were introduced at the trial end of the plaintiff's case. Meanwhile, I was in the courtroom of having to tell the jury 'It couldn't have been the midwife's,' without offering them another reasonable brain damage theory."

Fortunately, the plaintiffs rested their case on a Friday afternoon, giving JMT&K time for a weekend rally. "Twenty minutes later," says Kalur, "I was in the hospital pathologist's office with an order permitting me to view the mother's placental slides." Microscopic staining had been charted, and Kalur had a hunch that fetal distress had begun long before the for

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A 45-year-old female with abdominal pain, ascites, and bilateral uterine adnexal masses

Participants: Rene R. Genadry, M.D.;
Robert J. Kurman, M.D.; George P. Saba, M.D.;
and Charles E. Kramer, M.D.

PRESENTATION OF CASE

The patient is a 45-year-old white female, gravida 2, para 2, with a recent history of abdominal pain and increasing abdominal girth. The patient was in her usual state of good health until 20 months ago when she began to experience progressive abdominal pain. Examination three months later revealed ascites and bilateral uterine adnexal masses. A barium enema indicated the presence of an extrinsic mass in the pelvic and distended loops of bowel. Abdominal paracentesis cytology demonstrated adenocarcinoma cells. An endometrial biopsy revealed a mucin-secreting adenocarcinoma. An exploratory laparotomy demonstrated bilateral adnexal masses with disseminated cancer seeding the peritoneum, serosal surfaces of the intestine and urinary bladder, the peritoneal surface of the diaphragm, and the omentum. A total abdominal hysterectomy with bilateral salpingo-oophorectomy and a total omentectomy were performed. Residual tumor nodules of less than 1.0 cm in diameter remained after cytoreductive surgery. Estrogen and progesterone receptor assays of the tumor tissue were positive. The patient was treated with a single

cycle of chemotherapy consisting of cytoxan, adriamycin, and cisplatin, without response.

Two months later, the patient was hospitalized for a partial bowel obstruction. Colonoscopic examination and biopsy demonstrated the presence of an incidental tubular adenoma. A second abdominal paracentesis performed at this time revealed a few markedly atypical cells suspicious for tumor. The patient underwent endoscopy that revealed changes compatible with linitis plastica, but gastric brushings failed to confirm the presence of a gastric tumor. Nevertheless, the chemo-therapeutic regimen was changed to include 5-fluorouracil (5-FU), Adriamycin, and mitomycin-C. The patient continued to have persistent bowel obstruction related to extensive tumor involvement of the peritoneal cavity. She also developed edema of the upper extremities. A subsequent venogram demonstrated obstruction of the right subclavian, left innominate, and portions of the left subclavian veins, related either to catheter-induced thrombosis or, alternatively, Trousseau's syndrome. The patient was initially treated with streptokinase, which was subsequently discontinued because of conjunctival hemorrhage. She was then placed on intravenous (IV) heparin therapy that was continued following discharge.

At home, the patient developed edema of the face, especially periorbital (thought to be consistent with a superior vena caval syndrome), and edema of the right foot associated with prominent superficial veins.

Four months later, the patient developed ascites and a left pleural effusion for which chemotherapy was begun. Over the next nine months, she had multiple hospital admissions for presumed Hickman catheter-related sepsis. An abdominal computed tomography scan (CT) performed fourteen months after symptoms were first noted demonstrated increasing ascites and suggested carcinomatosis, which was confirmed by cytologic studies. The patient was treated with Megace and Tamoxifen without clinical response. She underwent upper gastrointestinal endoscopy four months later, which demonstrated severe esophagitis and hourglass deformity of the stomach. Cytologic and histologic examination demonstrated esophageal ulceration and gastric mucosal edema with chronic inflammation, but no cancer cells were identified. A gastrostomy tube was placed at this time, but the patient began to develop progressive dyspnea with associated hypoxemia and metabolic alkalosis thought to be related to gastric acid losses through the gastrostomy tube.

The past medical history elicited included curettage of a benign right lower extremity bone tumor at 15 years of age and upper arm fracture requiring open reduction and internal fixation at age 16.

From the Johns Hopkins School of Medicine where Dr. Genadry is associate professor, Department of Gynecology and Obstetrics; Dr. Kurman is professor of pathology and director of gynecologic pathology, Department of Pathology; Dr. Saba is associate professor and director of the Division of General Diagnostic Radiology; and Dr. Kramer is a pathologist in the Department of Pathology.

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Menarche was at age 15 with regular cycles. She had had cervical dilatation and endometrial curettage at 26 years of age, and an elective tubal ligation at 34 years of age. She had had two normal vaginal deliveries without complications, 21 and 24 years previously. There were no known drug allergies. There was no history of alcohol abuse or smoking. Her current medications included Carafate, Zantac, and Tylox for pain and hyperalimentation.

On physical examination, her temperature was 37.3° C, respirations were 20 per minute, pulse was 124 per minute, and blood pressure was 110/70 mm of mercury. She weighed 56.0 kg. She was a moderately well-nourished, well-developed white female with marked abdominal distention. Her cheeks were puffy, sclerae were non-icteric, and her pupils were equal, round, and reactive to light and accommodation. Her lungs were clear with decreased breath sounds bilaterally at both bases.

There were no breast masses or nipple discharge. Her heart rate was regular and the rhythm was normal without gallops, murmurs, or rubs. A well-healed, lower-abdominal, midline scar was present. The abdomen was soft and nontender with marked diffuse distention, unchanged from recent examination; there was no guarding or rebound. Bowel sounds were active. A gastrostomy tube was draining bile-colored fluid. Extremities showed mild lower-extremity edema. Neurologic examination showed no focal deficits.

Her serum sodium was 141 mEq/L; potassium, 4 mEq/L; chloride, 104 mEq/L; bicarb, 30 mEq/L; blood urea nitrogen (BUN), 25 mg/dl; creatinine, 0.9 mg/dl; glucose, 62 mg/dl; calcium, 8.4 mg/dl; uric acid, 2.2 mg/dl; total protein, 5.3 gm/dl; albumin, 2.9 gm/dl; alkaline phosphatase, 122 U/L; lactate dehydrogenase (LDH), 390 U/L; amylase, 70 U/L; hematocrit (Hct), 28.2 percent; white blood count (WBC), 11,200/mm³; and platelets, 40,000/mm³. Her mean corpuscular volume (MCV) was 98.6 fL. The prothrombin time (PT) was 1.1 x control and partial thromboplastin time (PTT) was 0.9 x control. The chest radiographs revealed bilateral pleural effusion that had not significantly changed from previous examination.

The patient was admitted for increasing respiratory distress and hypoxemia. A ventilation to perfusion ratio (V/Q) scan was interpreted to show a very low probability of pulmonary embolism. Subsequent thoracentesis demonstrated no cancer cells. The patient was anticoagulated without improvement. She developed progressive respiratory failure over the course of the following week, and expired after one month's hospitalization.

gravida 2, para 2, woman who presented with abdominal distention and pain. She was found to have bilateral adnexal masses and a carcinoma involving the endometrium. She was treated and developed recurrences despite very aggressive chemotherapy for ovarian cancer. She finally developed a hypercoagulable state and died within two years of the initial diagnosis.

Let us first review, for the purpose of the medical students, the presentation of a patient with progressive abdominal enlargement. The differential diagnosis should include obstructive intestinal lesions, pregnancy with hydramnios, large ovarian cysts, and ascites. In a woman of reproductive age, the most important diagnosis to consider is the possibility of pregnancy and its related complications. This is unlikely since this patient had a tubal ligation, but it must be considered nonetheless.

This patient presented with bilateral adnexal masses and ascites. Although inflammatory, infectious, or hepatic causes of ascites should always be considered, abdominal neoplasia remains the most likely etiology. Indeed, the combination of abdominal distention, ascites, and adnexal masses makes the probability of an ovarian neoplasm even more likely.

Let us focus for a while on the possible causes of an adnexal mass. An easy mnemonic can help one remember the possible sources of adnexal enlargement. It is the rule of the seven "Fs." The first three involve pelvic but nongynecological structures and include

1. The urinary tract (foley) including lesions arising in the bladder, ureters or kidneys; a pelvic kidney should always be part of the differential diagnosis.
2. The bowel tract (feces) including lesions arising from the rectosigmoid colon, mucosa of the appendix, or inflammatory small-bowel lesion.
3. The retroperitoneal structures (fat) including the neural, lymphatic, vascular, and soft tissue structures.

The last four "Fs" relate to the gynecologic tract and include

1. Pregnancy-related complications (fetus) including that of molar pregnancy and choriocarcinoma.
2. Tumors arising from the uterus (fibroids) including cervical, endometrial, and myometrial lesions.
3. Tumors arising from the (fallopian) tubes including inflammatory and neoplastic lesions.
4. Tumors arising from the (follicle) ovary, which is the most likely source of the bilateral adnexal enlargement in this patient with mucin-secreting carcinoma in the endometrium.

At this stage, one needs to consider the relationship of the mucin-secreting carcinoma in the endometrium to the bilateral adnexal enlargement. The first possibility includes an endometrial carcinoma with metastases to the ovaries. In that respect, it is important to rule out a concomitant inflammatory tubo-ovarian process; this process is unlikely in this patient due to her history of tubal ligation, lack of fever, and her clinical presentation.

The possibility of a functioning ovarian tumor or ovarian tumor with functioning matrix also must be considered. These tumors are notorious for inducing the development of proliferative lesions in the endometrial cavity. The most common of such lesions is a granulosa-theca cell tumor that has been found in association with both endometrial hyperplasia and endometrial cancer in as high as 15–20 percent of the cases.¹ It can be found in both postmenopausal and younger patients, but it is usually unilateral. We are told that the patient presented with bilateral adnexal masses. Furthermore, granulosa-theca cell tumors do not usually present with a rapidly progressive and downhill course. In any event, hormonal secretion from the stimulated ovarian stroma of many types of ovarian tumors also can have an effect on the endometrial lining. Mucinous tumors and Brenner tumors are especially noted for secreting estrogens which stimulate the lining of the uterus, producing endometrial hyperplasia and endometrial cancer.²

Finally, one ought to consider the possibility that a primary uterine lesion could have metastasized to the ovaries. It is not uncommon to have carcinomas arise simultaneously in the endometrial lining of the uterus and on the surface of the ovaries because of the totipotent ability of cells derived

from the Mullerian duct to undergo neoplastic changes at various pelvic sites. Notoriously, these usually do not behave like metastatic disease.³

Perhaps at this stage we could get some help from reviewing the available endometrial biopsy.

Dr. Robert J. Kurman: The patient's vaginal bleeding led her gynecologist to perform an endometrial biopsy. The endometrium, under low magnification, is remarkable for its mixture of both normal endometrial glands and abnormal cells (**Figure 1**). A number of the abnormal cells that are scattered throughout the endometrial stroma have clear, somewhat vacuolated, cytoplasm with eccentric nuclei. These cells, with eccentric nuclei which are displaced to the margin of the cell, are referred to as signet-ring cells. A mucicarmine stain revealed that the clear cytoplasm contained abundant mucin. The biopsy was interpreted as containing mucinous, signet-ring adenocarcinoma cells.

Dr. Genadry: Mucus-secreting uterine cancer has been reported in both the endocervix and in the endometrium, but the latter is rare. In this patient, the presence of normal endometrial glands and the distribution of the mucin-secreting cells in the stroma suggest the possibility of a neoplasm that has invaded the endometrium secondarily, rather than a lesion that has arisen primarily from the endometrium.

There is an adage in gynecology that any patient who presents with an adnexal mass in association with ascites and abdominal distention has to have ovarian neoplasia until proven otherwise. Since we have mucin-secreting carcinoma cells, we must consider the possibility of a mucinous cystadenocarcinoma of the ovary. Mucinous cystadenocarcinoma of the ovary, however, is rarely bilateral. It is possible that in late-stage disease, it could involve both ovaries, but that is not a common presentation.

A type of mucin-secreting carcinoma in the ovary is referred to as Krukenberg tumor. When dealing with Krukenberg tumor, a key question is whether it is primary or secondary. Approximately 20 percent of cases of Krukenberg tumor are primarily ovarian (i.e., no obvious source for primary mucin-secreting adenocarcinoma could be found).⁴ Usually, these patients do better clinically. In view of this particular patient's poor course, an extraovarian primary must exist.

At this point, we could look for radiological clues from her film library.

Dr. George P. Saba: I selected a few films

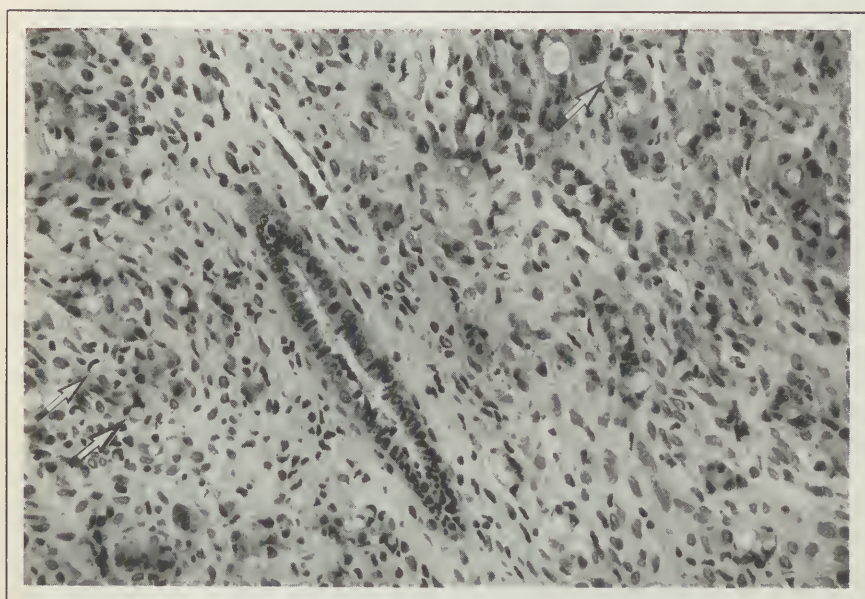


Figure 1. Endometrial biopsy: The stroma contains small clusters of malignant cells, many of which have signet-ring cell features (arrows). A benign endometrial gland is in the center of the field. (Hematoxylin-eosin, X 320).

from a number of films taken over a two-year course. A plain film of the abdomen early in the illness shows a moderate amount of free fluid and/or ascites in the abdomen. A few months later, an anterior-posterior film (**Figure 2**) from an air-contrast barium enema shows that the cecum is deformed medially, and there is also deformity and spiculation of the sigmoid colon. A lateral film (**Figure 3**) shows barium introduced into the rectum via a tube

placed in the rectum. There is spiculation of the rectosigmoid area with the mass affected both anteriorly and posteriorly in this area, probably due to metastatic disease in the cul-de-sac. The findings are characteristic of a tumor involving the sigmoid and rectum that has gravitated to the pelvic recesses and cul-de-sac and also into the right paracolic gutter to deform the base of the cecum.

A chest film (**Figure 4**) taken a few months before the patient's demise revealed moderate bilateral pleural effusions.

The radiographic findings are compatible with either a primary tumor in the stomach wall with metastatic disease to the remainder of the abdomen or a primary process in the abdomen with metastatic disease to the greater curvature of the stomach.

In the patient's upper gastrointestinal (GI) examination, the stomach is deformed along its greater curvature (**Figure 5**) with a slight increase in the space between the stomach and the air in the transverse colon. This suggests metastatic disease and/or a primary carcinoma of the greater curvature of the stomach.

Dr. Genadry: We are thus dealing with a patient with disseminated disease and bilateral adnexal masses. We know the disseminated disease involves the endometrial lining, but it also seems to involve the entire peritoneal cavity, the stomach, the small bowel, and the rectosigmoid colon. The question remains as to where it is coming from. The positive estrogen and progesterone receptors focus attention on



Figure 2. Anterior-posterior radiograph showing medial deformity of cecum (arrow, left) and spiculation and deformity of the sigmoid colon (arrow, right).



Figure 3. Lateral view of the sigmoid-rectal area showing tumor encasing this portion of the bowel due to involvement in the cul-de-sac (arrow heads).



Figure 4. Chest radiograph showing bilateral pleural effusions.



Figure 5. Radiograph showing deformity of greater curvature of stomach (arrows) and separation of greater curvature of stomach from air in transverse colon due to tumor.

the gynecological system, but what other sites of origin should we consider for this mucin-secreting lesion? Could it be a cancer in the rectosigmoid? Colonoscopy has ruled that possibility out. Could it be a mucocoele of the appendix that occasionally can present as a mucin-secreting metastatic tumor? This cannot be ruled out with 100 percent certainty. The stomach does show linitis plastica changes compatible with an infiltrative process, but none of the interventional-pathologic diagnostic studies that were done were able to prove the presence of any gastric mucosal lesion. In conclusion, I think I will have to say that this patient had Krukenberg tumor. The clinical course of this patient, including lack of response to the ovarian chemotherapeutic regimen suggests metastatic disease to the ovary. The most likely primary site of Krukenberg tumor is the distal stomach. From the radiographs, this seems to be where the bulk of the disease is. Cancer seems to involve the entire covering of the peritoneal cavity. Disease features are consistent with ovarian neoplasia, but disease course and state are so advanced that a primary gastric lesion might explain it.

Dr. Rene R. Genadry's diagnosis
Krukenberg tumor of probable gastric origin.

DISCUSSION OF PATHOLOGY

Dr. Kurman: Dr. Genadry's thinking in this case was very similar to that of the patient's gynecologist. When the patient first presented with bilateral pelvic masses and ascites, the gynecologist believed quite strongly that despite her relative young age, the patient had ovarian cancer. Because of the vaginal bleeding, he did an endometrial biopsy and, with the pathologic diagnosis of a mucin-secreting adenocarcinoma, he, like Dr. Genadry, believed the tumor was metastatic to the ovaries and probably arose from the stomach.

At surgery, there was widespread carcinomatosis involving the entire peritoneal cavity. The ovaries were enlarged but retained the convoluted appearance of normal ovaries. On cut section, the ovaries were homogeneous, gelatinous, and solid, characteristic of Krukenberg tumor. The microscopic findings confirmed the diagnosis of Krukenberg tumor, which is characterized by two cellular components. Some cells look like fibroblasts, but interspersed among them were signet-ring cells (Figure 6). The latter had the same features as those present in the endometrium. It was the spindle-shaped cells that led Dr. Krukenberg, in 1896, to describe this as a primary mucinous fibrosarcoma of the ovary.⁵

On high magnification, the signet-ring cells were shown to contain abundant intracytoplasmic mucin. These cells diffusely infiltrated the ovarian stroma and all of the organs removed at the time of the hysterectomy. Tumor cells were present

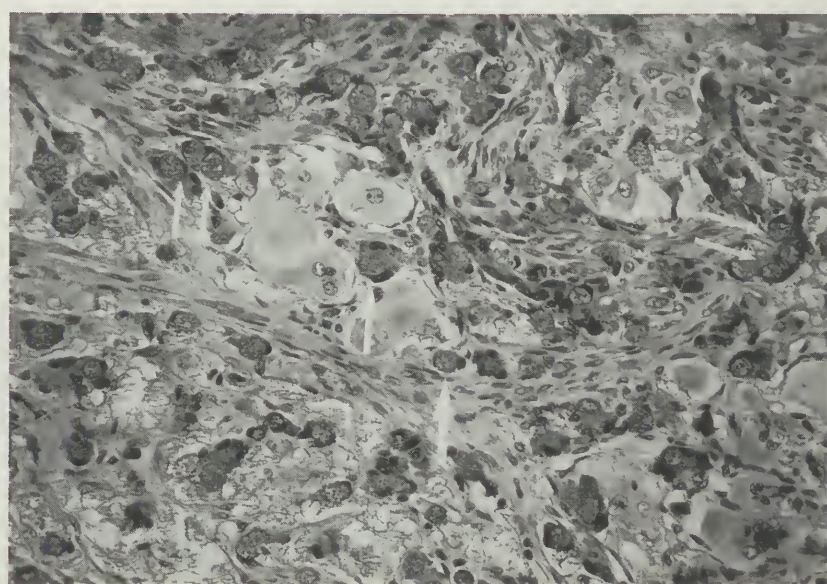


Figure 6. Krukenberg tumor of ovary. Many mucin-containing signet-ring cells (arrows) are seen set in a reactive spindle-cell stroma (mucicarmine stain, X 320).

throughout the wall of the fallopian tubes, cervix, endomyometrium, omentum, peritoneal biopsies, bladder, and rectal biopsies. Tumor emboli plugged vascular and lymphatic channels in all these sites—another characteristic feature of this neoplasm.

Most Krukenberg tumors are first recognized at the time of hysterectomy rather than preoperatively. This case was unusual in that there was a clue to the diagnosis of Krukenberg tumor by virtue of the endometrial biopsy. Even with that information, however, it was not possible to make the diagnosis intraoperatively. There was extensive carcinomatous involvement of the peritoneal cavity simulating metastatic ovarian carcinoma. Careful palpation could not identify a mass within the stomach so that the tumor was still considered to be of ovarian origin. A primary Krukenberg tumor was considered, and cytoreductive surgery was performed leaving residual disease measuring less than 1 cm. A course of chemotherapy for ovarian cancer was begun, but there was no response. Ascites, in fact, increased. The possibility of a non-ovarian primary site was considered, and chemotherapy was changed to 5-FU, mitomycin, and actinomycin (used for the treatment of primary gastrointestinal carcinoma). The patient had a good clinical response that unfortunately, was limited to only two months. At that time, there was massive recurrence. Despite multiple endoscopic and gastroscopic examinations with biopsies, no tumor could be identified in the stomach before autopsy.

At the time of autopsy, the patient had extensive tumors involving the abdominal cavity. The stomach displayed the characteristic leather-bottle appearance (so-called linitis plastica)—a shrunken, thickened stomach secondary to diffuse infiltration by tumor cells. There was extensive gastritis and reflux esophagitis secondary to obstruction.

Microscopically, the stomach was diffusely infiltrated by tumor cells which spared the mucosa. There was marked inflammation and ulceration, but no tumor on the mucosal surface. This accounted for the inability of the numerous biopsies to confirm the diagnosis of a gastric carcinoma (Figure 7).

There was involvement of the capsule of the liver, spleen, urinary bladder, and lungs. In the latter, both lymphangitic and parenchymal involvement were evident.

When a gynecologist is confronted by bilateral ovarian masses, the likelihood of metastatic tumor is about one in twenty. It is important to keep that in mind—especially in a young woman—since we usually do not think of metastatic carcinoma in a 45-year-old woman. As Dr. Genadry said, in the reproductive age group, one needs to think first

about problems relating to pregnancy. Adenocarcinoma of the colon is the most common tumor to metastasize to the ovary since the prevalence of gastric carcinoma has decreased in the United States.⁶ The second most common neoplasm is breast carcinoma, although this tumor does not usually present with large ovarian masses. Ovarian involvement by breast carcinoma is typically microscopic. Most cases of breast cancer metastatic to the ovaries are detected at the time of oophorectomy in women who are being hormonally treated.⁷

It should also be emphasized that the diagnosis of Krukenberg tumor should be limited to metastatic carcinoma with a specific histology. As previously noted, Krukenberg originally described the tumor that bears his name as a primary ovarian tumor. This mistake was rectified a few years later by Schlagenhofer who described it as a metastatic carcinoma probably arising in the stomach. Drs. Woodruff and Novak from this institution subsequently established specific criteria for Krukenberg tumor that include the presence of a mucin-secreting signet-ring cell carcinoma and fibroblast-like cells that simulate a sarcoma. The latter are reactive.⁸ In addition to the colon and stomach, primary sites may be in the appendix, the gallbladder, and the urinary bladder.^{9,10}

It is of interest that Krukenberg tumors involve young women. The mean age is 40 years. The reason for the preponderance in young women is that worldwide, most Krukenberg tumors arise from diffuse or signet-ring cell carcinomas of the stomach. Gastric carcinomas can be divided into two categories: the intestinal type and the Krukenberg or signet-ring cell type. It is the signet-ring cell type that occurs in young people, usually women, and it is

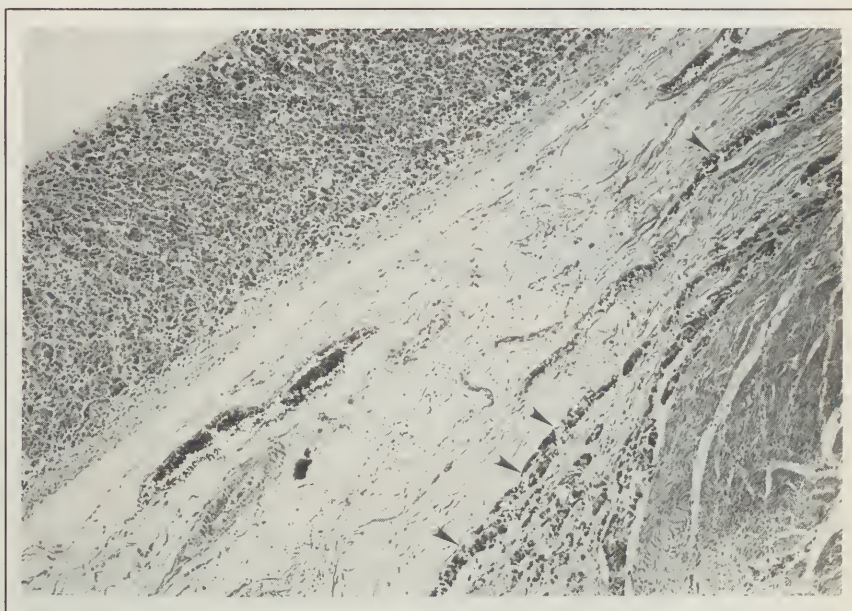


Figure 7. Low-power micrograph of stomach with intact mucosa. The submucosa contains a poorly differentiated infiltrating carcinoma (arrow heads). (Hematoxylin-eosin, X 80).

this neoplasm that tends to metastasize to the ovary.⁹ Secondly, the ovaries in young women are more highly vascular than in older women.

A point that was raised by Dr. Genadry is that stimulation of the endometrium leading to abnormal bleeding could result from a functioning ovarian tumor. Sometimes Krukenberg tumors are associated with virilization. This occurs more often during pregnancy.

Finally, Dr. Genadry differentiated a primary Krukenberg tumor from a metastatic Krukenberg tumor. That is a controversial subject because, in order for Krukenberg tumor to qualify as a primary neoplasm, two criteria must be fulfilled. Either the patient must remain alive for five years without evidence of tumor elsewhere following a diagnosis of a Krukenberg tumor of the ovary or, if the patient dies, a complete autopsy must show that no tumor exists elsewhere.⁹ Gastric carcinoma, however, is the most common neoplasm resulting in Krukenberg tumor, and these neoplasms can occasionally be clinically silent for more than five years. Therefore, ovarian neoplasia could still be metastatic without its primary source being appreciated. Sometimes the primary tumor in the stomach may be very small and could be missed even at autopsy.

Dr. Belur S. Bhagavan: Relative to the discussions of primary versus secondary carcinoma (Krukenberg tumors) of the ovary, it is worth noting that initial attempts to determine the origin of the patient's neoplasm included study of sex hormone receptors (i.e., estrogen receptors (ER) and progesterone receptors (PGR) of the tumor tissue). Some questions that may be raised include

- Are the receptor studies of value in determining the primary source of disseminated adenocarcinoma?
- Do cancers with receptor positivity, regardless of the source of origin, behave and respond to treatment as if they were derived from tissues expected to carry such receptors (e.g., breast cancer)?
- How often, in fact, do nonendocrine normal tissue cells express ER and PGR?

Dr. Kurman: Sex hormone receptors have been found in many hormone-dependent tumors such as breast, prostate, and endometrium, and the levels of receptors in these tumors have been used as an indicator for the choice of treatment. The receptors have also been used as an indicator for determining if a metastatic cancer from an unknown primary could be of breast or genital-tract origin. The presence of ER and PGR has been described in a number of apparently non-sex-hormone-dependent tumors, including malignant melanoma, and carcinomas of

the colon, kidney, pancreas, and stomach.¹¹⁻¹⁹ Even normal gastric mucosa and normal gastric tissues have been shown to contain ER and PGR.¹⁸ Thus, receptor protein assays are not likely to be helpful in discriminating between breast and genital-tract tumors and non-sex-hormone-dependent tumors such as gastric carcinomas.

Furthermore, some studies have shown that anti-estrogen (e.g., tamoxifen) has a beneficial effect on survival of patients with gastric carcinoma.^{15,17} Others have shown no beneficial effect with tamoxifen therapy, and, indeed, patients with ER positive gastric cancers have shown a decrease in survival time.¹⁹ Thus, all cancers with receptor positivity regardless of the source of origin may not be expected to behave or respond to treatment in a uniform or predictable manner.

Anatomical diagnosis Krukenberg tumor of gastric origin.

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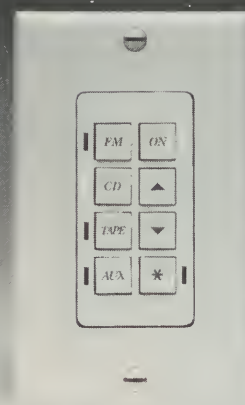
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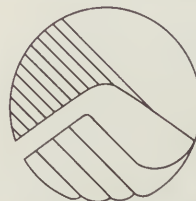
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Component Society Presidents 1992

Med Chi's component medical societies are the backbone of Maryland's family of medicine. This section of the *Maryland Medical Journal* is dedicated to the leaders of Med Chi's component societies and features biographical information on the component society presidents.



Allegany County
Francisco Reyes, M.D.

Francisco Reyes, M.D. assumed the office of president of the Allegany County Medical Society in January 1992. Born in Nicaragua, Dr. Reyes obtained his professional degree from the Universidad Nacional Autonoma de Nicaragua in 1968. Dr. Reyes fulfilled his internship at the Hospital General de Managua and completed his surgical residency requirements at the Instituto Nacional de Seguridad Social in Nicaragua. From October 1969 to June 1970, Dr. Reyes practiced general medicine in Managua, Nicaragua. In 1970, Dr. Reyes moved to Elyria, Ohio and completed postdoctoral training in a rotating internship at Elyria Memorial Hospital. From July 1971 to June 1975, Dr. Reyes continued his medical training in the United States through a residency in pathology. He served as a fellow in surgical pathology at the University of Maryland Hospital from July 1975 to July 1976. Dr. Reyes currently maintains a pathology practice with Sacred Heart Hospital in Cumberland. ■



Anne Arundel County
Jaime Accinelli, M.D.

Jaime Accinelli, M.D. became president of the Anne Arundel County Medical Society on December 31, 1991. Dr. Accinelli received his medical degree in 1958 from San Marcos University in Lima, Peru. He served his internship and completed a residency in obstetrics and gynecology at Bon Secours Hospital in Baltimore. From 1963 to 1965, he served as acting chief of obstetrics and gynecology at the US Army Hospital in Fort Rucker, Alabama. Dr. Accinelli has served as chairperson of the Department of Gynecology at North Arundel Hospital in Glen Burnie since 1980. ■



Baltimore City
Allan Jensen, M.D.

Allan D. Jensen, M.D. assumed the office of president of the Baltimore City Medical Society on December 7, 1991. Born in Chicago, Illinois, Dr. Jensen received his medical degree from the Johns Hopkins University in 1968. The following year, he completed his internship at Union Memorial Hospital in Baltimore. From 1969 to 1972, Dr. Jensen was a resident at the Wilmer Ophthalmological Institute of the Johns Hopkins Hospital where he participated in a residency exchange program at Khalili Hospital in Shiraz, Iran. From 1972 to 1973, Dr. Jensen served as a cornea fellow for the Massachusetts Eye and Ear Infirmary at the Harvard Medical School and Retina Foundation in Boston, Massachusetts. Upon his return to Baltimore, he became chief resident at the Wilmer Ophthalmological Institute.

During his service as a major in the US Air Force from 1974 to 1976, Dr. Jensen worked in the Ophthalmology Service at the Wilford Hall Medical Center at the Lackland Air Force Base in Texas. Dr. Jensen's past academic appointments include instructor of ophthalmology at the Johns Hopkins University and at the University of Texas in San Antonio. He is currently an assistant professor of ophthalmology at the Johns Hopkins University and chief of ophthalmology at Union Memorial Hospital. He is also a member of the hospital staff at the Johns Hopkins Hospital and the Greater Baltimore Medical Center. ■



Baltimore County
Louis C. Breschi, M.D.

Louis C. Breschi, M.D. was installed as president of the Baltimore County Medical Association in January 1992. A graduate of the University of Maryland School of Medicine, Dr. Breschi completed his rotating internship at the Carswell Air Force Base Hospital in Fort Worth, Texas in 1963. Over the next four years, Dr. Breschi completed his urology residency and the first year of his surgical residency at the University of Maryland Hospital. In 1967, he began working as a urologist at the Wright Patterson Air Force Base in Dayton, Ohio where he later became chief of urology. Dr. Breschi served in Vietnam from 1970 to 1971 as chief of the Urology Service and chief of the Surgical Service at the 483rd US Air Force Hospital in Cam Rahn Bay where he received a bronze star for meritorious service. Upon his return, Dr. Breschi was an instructor in urology and later became an assistant clinical professor in urology at the University of Maryland School of Medicine. From 1972 to 1991, Dr. Breschi was consultant in urology at the James Kernan Hospital. Dr. Breschi currently serves on the medical staffs of Good Samaritan Hospital, St. Joseph Hospital, and Franklin Square Hospital, where he served as president from 1985 to 1987. ■



Calvert County
Joseph S. Fastow M.D., M.P.H.

Joseph S. Fastow M.D., M.P.H. began his second term as president of the Calvert County Medical Society in January 1992. A 1962 graduate of Rutgers University, Dr. Fastow received his medical degree from the Boston University School of Medicine. He fulfilled his internship requirements at the Pennsylvania Hospital in Philadelphia and later went on to become assistant resident in anesthesiology (intensive care medicine) at the George Washington University Hospital in Washington, DC. From 1971 to 1973, Dr. Fastow served in the military, working for the US Public Health Service, the Food and Drug Administration, and the National Heart and Lung Institute. From 1974 to 1977, Dr. Fastow completed a residency and fellowship in emergency medicine at the Johns Hopkins Medical Institutions. In 1977, he earned an M.P.H. from the Johns Hopkins University School of Hygiene and Public Health. He took a position as clinical instructor for the Georgetown University School of Medicine where he later advanced to clinical assistant professor in 1981. A fellow of the American College of Emergency Physicians, Dr. Fastow has held a number of positions including assistant director to the Department of Emergency Medicine at the Doctors' Hospital of Prince George's County and staff physician at the Department of Emergency Medicine at Holy Cross Hospital. He has been director of Emergency Services for Calvert Memorial Hospital in Prince Frederick, Maryland since 1985. ■



Caroline County
Christian E. Jensen, M.D.

Christian E. Jensen, M.D. has served as president of the Caroline County Medical Society for thirteen years. A graduate of Duke University Medical School, Dr. Jensen served his internship at the Naval Hospital in Portsmouth, Virginia and then immediately entered into a private family medicine practice in Denton, Maryland. In 1982, Dr. Jensen accepted a position as medical supervisor for E.I. Dupont De Nemours in Seaford, Delaware. During his eight-year tenure with that company, Dr. Jensen completed a mini-residency in occupational medicine at the University of Cincinnati College of Medicine and graduated from the Naval War College in Newport, Rhode Island. In 1990, he received an M.P.H. from the Medical College of Wisconsin and became president of the board of trustees and corporate medical director of the Delmarva Foundation in Easton, Maryland. He is a fellow of the American College of Family Physicians and has "Master" status in the American College of Occupational and Environmental Medicine. In addition to his active medical practice, Dr. Jensen is the physician for the Caroline County Jail. He is also a captain in the US Naval Reserve, a Desert Storm veteran, and commanding officer of a naval reserve preventive medicine unit. ■



Carroll County

James L. Forsberg, M.D.

James L. Forsberg, M.D. became president of the Carroll County Medical Society on January 1, 1992. A 1983 graduate of the University of Rochester School of Medicine and Dentistry, Dr. Forsberg served his internship and residency at York Hospital in York, Pennsylvania. Dr. Forsberg is currently staff physician at the Carroll Primary Care offices in Westminster and Sykesville. He is also a member of the medical staff at Carroll County General Hospital in Westminster. ■



Cecil County

Henry Farkas M.D., M.P.H., F.A.C.E.P.

Henry Farkas M.D., M.P.H., F.A.C.E.P. began his seventh year as president of the Cecil County Medical Society in January 1992. Dr. Farkas was born in New York City, at-

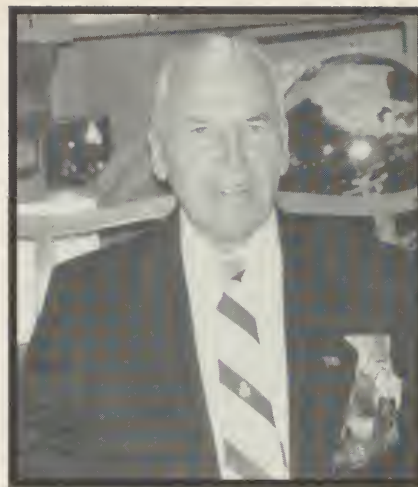
tended Loyola College, and earned his medical degree from the Johns Hopkins Medical School in 1970. In 1971, he received his M.P.H. from the Johns Hopkins School of Hygiene and Public Health. After completing his internship at the Lancaster General Hospital in Lancaster, Pennsylvania, Dr. Farkas served as general medical officer for the US Public Health Service on a Navajo reservation in Chinle, Arizona. In 1973, he returned to Maryland where he served as an emergency physician for Harford Memorial Hospital. From 1984 to 1990, Dr. Farkas worked as medical director for the Cecil County Detention Center. Dr. Farkas now practices emergency medicine at Union Hospital of Cecil County. He also holds positions as medical director for the Northern Chesapeake Hospice and the Medical Adult Day Care Center of Union Hospital of Cecil County. ■



Charles County

Paul S. Pritchett, M.D.

Paul S. Pritchett, M.D. became president of the Charles County Medical Society on January 1, 1992. After graduating from the Howard University College of Medicine in 1971, Dr. Pritchett completed his internship at the Wilford Hall US Air Force Medical Center in Lackland, Texas. Dr. Pritchett completed his residency in family practice at the Malcom Grow US Air Force Medical Center at Andrews Air Force Base in 1974. After retiring from the military in 1988, Dr. Pritchett entered into a private practice in LaPlata, Maryland. In addition to his practice, he is also medical director for the Charles County Nursing Home in LaPlata. ■



Frederick County

Henry P. Laughlin M.D., Sc.D., Sc.S.D.

Henry P. Laughlin M.D., Sc.D., Sc.S.D. became president of the Frederick County Medical Society on January 1, 1991 and is the first physician to have held the office of president in both Frederick and Montgomery counties. A native of Hagerstown, Dr. Laughlin attended the Johns Hopkins University and earned a B.S. from Ursinus College in 1938. He obtained his medical degree from the Temple University School of Medicine in 1941. Following graduation, he served over seven years as a US Navy physician and surgeon during World War II in the American, Caribbean, African-European, and Asiatic theaters of operation, as well as in the United States. Following the war, Dr. Laughlin maintained a private practice as a specialist in psychiatry for forty years in the Chevy Chase, Bethesda, and Frederick areas. During that time, he was a fellow of the AMA and the Washington Medical and Surgical Society. He was a faculty member at the George Washington University Medical School for thirty-five years, the last six with the rank of clinical professor. From 1974 to 1989, Dr. Laughlin served as distinguished visiting professor at the University of Louisville School of Medicine. Dr. Laughlin is the recipient of numerous awards and holds an honorary Sc.D. degree from Ursinus College and an Sc.S.D. degree from the University of Louisville. Dr. Laughlin currently serves as associate editor for the *Maryland Medical Journal*. He is also an emeritus staff member of Suburban Hospital in Bethesda and Frederick Memorial Hospital. ■



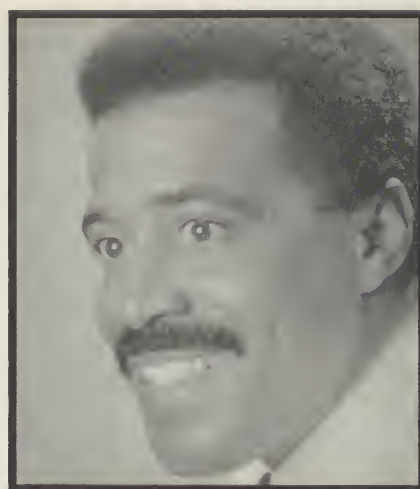
Garrett County
John L. Pocaro, M.D.

John L. Pocaro, M.D. began his third term as president of the Garrett County Medical Society in January 1992. Born in New York City, Dr. Pocaro graduated from the University of Medicine and Dentistry of New Jersey (UMDNJ) in Newark where he began his residency in general surgery in 1978. He moved on to become a resident in ear, nose, throat, head, and neck surgery at the Columbia University College of Physicians and Surgeons in New York. Dr. Pocaro returned to UMDNJ to complete his residency training in general surgery and later became a fellow in vascular surgery in 1982. A fellow of the American College of Surgeons, Dr. Pocaro was appointed as clinical assistant professor of surgery for the West Virginia University. He is currently chief of staff and chief of the Anesthesia Department for the Garrett County Memorial Hospital. ■



Harford County
Peter Kang, M.D.

Peter Kang, M.D. became president of the Harford County Medical Society on January 1, 1992. Dr. Kang graduated from the Seoul National University School of Medicine in Korea in 1962. From 1967 to 1970, Dr. Kang completed his residency in anesthesiology at the Johns Hopkins Hospital in Baltimore. For the next four years, Dr. Kang was an instructor of anesthesiology at the Johns Hopkins University School of Medicine. A fellow of the American College of Anesthesia, Dr. Kang currently serves as chairperson of the Department of Anesthesia for Harford Memorial Hospital. ■



Howard County
Melvin S. Rapelyea, M.D.

Melvin S. Rapelyea, M.D. became president of the Howard County Medical Society in January 1992. Born in Queens, New York, Dr. Rapelyea received his medical degree from the University of Rochester School of Medicine. From 1976 to 1978, he completed his surgical internship and first year of surgical residency at the North Shore University Hospital at the Teaching Affiliate of Cornell Medical School in Manhasset, New York. Following his surgical training, Dr. Rapelyea served as a radiology resident at the North Shore University Hospital. In 1981, Dr. Rapelyea moved to Maryland and worked as a contract radiologist for a number of medical groups including Flynn Radiology Group, Computerized Radiology Associates, and Prince George's Radiology Group and served as a contract radiologist for the Medical Dispensary at General Electric. Dr. Rapelyea is currently assistant chairperson of radiology at Howard Community Hospital where he is also on several hospital committees and is a partner with Diagnostic Radiology Associates in Columbia, Maryland. ■



Kent County.

Douglas M. Cummings M.D., F.A.C.S.

Douglas M. Cummings, M.D., F.A.C.S. has been president of the Kent County Medical Society since January 1991. After graduating from the US Military Academy at West Point, New York, Dr. Cummings served in Vietnam for six years before entering medical school. He graduated from the University of Arkansas School of Medicine in Little Rock in 1976. He completed his internship and residency in urology at the Walter Reed Army Medical Center in Washington, DC. He retired from the military in 1988 after six years of solo practice at the Fort Meade Army Hospital and established a private practice in Chestertown. A fellow of the American College of Surgeons, Dr. Cummings currently resides in Betterton, Maryland. ■



Montgomery County

**Carol W. Garvey, M.D., M.P.H.,
F.A.A.F.P., F.A.C.P.M.**

Carol W. Garvey, M.D. M.P.H., F.A.A.F.P., F.A.C.P.M. became president of the Montgomery County Medical Society on April 21, 1992. After receiving a medical degree from the Columbia University College of Physicians and Surgeons in 1969, Dr. Garvey served her internship and residency at the Washington Hospital Center in Washington, DC. In 1973, Dr. Garvey became a fellow in the Harvard Family Health Care Program at the Children's Medical Center and Harvard Medical School. In 1975, she received an M.P.H. from the Harvard School of Public Health. While in Massachusetts, Dr. Garvey was an instructor in the Department of Medicine at the Boston University School of Medicine. She also worked as a physician for the Boston Family Planning Project and as a consultant for the Massachusetts Federal/State Family Planning Committee. In 1976, Dr. Garvey moved to Maryland where she worked as a medical officer for the Bureau of Community Health Services in the US Department of Health and Human Services in Rockville. In addition to a private practice in family medicine, Dr. Garvey is a clinical assistant professor at Georgetown University School of Medicine and is on the medical staff at Suburban Hospital. ■



Prince George's County

Brian S. Bayly, M.D.

Brian S. Bayly, M.D. became president of the Prince George's County Medical Society on January 1, 1992. A graduate of the Georgetown University School of Medicine, Dr. Bayly fulfilled his internship in surgery at the University of New Mexico and at the Georgetown University Affiliated Hospitals in Washington, DC. In 1979, Dr. Bayly received a fellowship in peripheral vascular surgery at the Washington Vascular Clinic in Cheverly, Maryland. He completed his surgical residency training in 1979 at the Georgetown Affiliated Hospitals in Washington, DC. Dr. Bayly currently holds privileges at Doctors Community Hospital, Greater Laurel/Beltsville Hospital, Leland Memorial Hospital, and Prince George's Hospital Center. He holds courtesy privileges at Holy Cross Hospital, Washington Adventist Hospital, and Washington Hospital Center. ■



Queen Anne's County
John R. Smith, Jr., M.D.

John R. Smith, Jr., M.D. began his fifth term as president of Queen Anne's County Medical Society in January 1992. A graduate of the University of Maryland School of Medicine, Dr. Smith served his internship and first year of residency at the Union Memorial Hospital from 1947 to 1949. Dr. Smith completed his residency at the Hospital for Women of Maryland. In 1950, he was a fellow in internal medicine at Johns Hopkins Hospital. The following year, while serving as a captain in the US Air Force, he became chief of medicine at the Mitchell Air Force Base in Garden City Long Island, New York. From 1954 to 1960, Dr. Smith maintained a private practice in New York City. During this period, Dr. Smith was also an instructor in medicine at Cornell Medical School and an attending physician at the New York Hospital for Cornell Medical School. Since 1960, Dr. Smith has practiced internal medicine in Centreville, Maryland. ■

St. Mary's County
James C. Boyd, M.D. (photo not available)

James C. Boyd, M.D. began his second term as president of St. Mary's County Medical Society in January 1992. Dr. Boyd received his medical degree from George Washington School of Medicine in 1974. From 1974 to 1977, he served his internship and residency at the University of Maryland Hospital. Dr. Boyd currently maintains a private practice in internal medicine in Leonardtown, Maryland. ■



Talbot County
David A. Stout, M.D.

David A. Stout, M.D. became president of the Talbot County Medical Society in July 1991. A graduate of Loma Linda University Medical School in Loma Linda, California, Dr. Stout served his internship and residency in pathology at the Yale-New Haven Hospital in New Haven, Connecticut. From July 1966 to July 1968, he served in the military as a surgeon for the US Public Health Service. In 1968, he began a two-year residency in clinical pathology at the National Institutes of Health in Bethesda. From 1970 to 1975, Dr. Stout was attending pathologist at Kent and Queen Anne's Hospital and at LeLand Memorial Hospital. He is currently a consulting pathologist at Dorchester General Hospital and attending pathologist at Memorial Hospital in Easton, Maryland. ■



Wicomico County
Ignatius Loyola Di Nardo, M.D.

Ignatius Loyola Di Nardo, M.D. assumed the office of president of Wicomico County Medical Society on January 1, 1992. Dr. Di Nardo graduated from the Georgetown University School of Medicine in 1983. He served an internship at Baltimore City Hospitals and completed his residency at the Francis Scott Key Medical Center. In 1983, Dr. Di Nardo began a three-year fellowship in internal medicine with the Johns Hopkins University School of Medicine. From June 1985 to June 1986, Dr. Di Nardo worked as an emergency room physician for the Wyman Park Health System in Baltimore. Dr. Di Nardo is currently the medical director of Somerset Medical Center and a staff physician for the Peninsula Regional Medical Center. ■

Worcester County

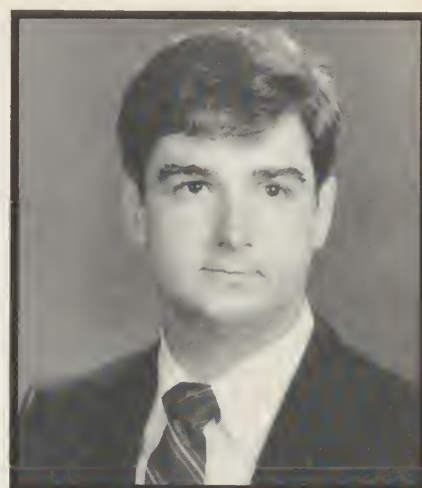
Stephen F. Waters, M.D. (photo not available)

Stephen F. Waters, M.D. began his third term as president of the Worcester County Medical Society in January 1992. Born in Gettysburg, Pennsylvania, Dr. Waters received his B.A. in biology from the Catholic University of America in Washington, DC. He studied at the Catholic University of America and the University of Maryland before entering the Georgetown University School of Medicine in 1976. After receiving his M.D. in 1980, Dr. Waters served a family practice residency at Franklin Square Hospital until 1983. Dr. Waters currently maintains a private practice in family medicine and ambulatory medicine at the Ocean City Medical Center. ■



Resident Component Society
Eric Lon Shampaine, M.D.

Eric Lon Shampaine, M.D. became president of the Resident Component Society of the Medical and Chirurgical Faculty of Maryland in July 1991. Graduating with distinction in research from the University of Michigan Medical School in 1988, Dr. Shampaine served his internship in the Transitional Program at St. Joseph Mercy Hospital in Ann Arbor, Michigan. In 1989, he received the Intern of the Year Award "in recognition of outstanding duties performed" and began his residency in anesthesiology at the Johns Hopkins Hospital. In 1992, Dr. Shampaine completed a fellowship in cardiac anesthesia at the Johns Hopkins Hospital. Specializing in cardiac anesthesia, Dr. Shampaine will begin a faculty appointment as an attending physician in anesthesiology at The Johns Hopkins Hospital in July 1992. ■



Student Component Society
W. David Sullivan

W. David Sullivan, a fourth-year medical student at the Johns Hopkins University, is currently serving as president of the Medical Student Component Society of the Medical and Chirurgical Faculty of Maryland. Born in Mississippi, Mr. Sullivan graduated from the University of Southern Mississippi in 1987. He spent his first postgraduate year studying at the Federal Institute of Technology in Zurich, Switzerland as a Fulbright scholar. Mr. Sullivan currently serves as an alternate delegate for Med Chi's Delegation to the American Medical Association (AMA) and attended the AMA's 1991 annual and interim meetings. ■

Med Chi would also like to recognize those component presidents whose biographical information was not available at press time:

Dorchester County
James F. McCarter, M.D.

Somerset County
James A. Sterling, M.D.

Washington County
John G. Newby, M.D. ■

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Board of Physician Quality Assurance Actions

**In the matter of
S. Edward Bradford, P.A.
before the
Maryland Board of
Physician Quality Assurance
Consent order**

Based on information received by the State Board of Physician Quality Assurance (the board), pursuant to its authority under *Md. Health Occ. Code Ann.* §15-314, charged S. Edward Bradford (the respondent), physician assistant (P.A.), under §15-314(2), (4), and (5) (1991 Repl. Vol.), in Charges Under the Medical Practice Act, incorporated herein as Exhibit A.

The pertinent provision of §15-314 provide

Subject to the hearing provisions of §15-315 of this subtitle, the board, on the affirmative vote of a majority of its members then serving, may reprimand any certificate holder or suspend or revoke a certificate if the certificate holder

- (2) Fraudulently or deceptively uses a certificate;
- (4) Performs delegated medical acts beyond the scope of the certificate not within a job description approved by the board; and
- (5) Performs delegated medical acts without the supervision of a physician.

Respondent voluntarily surrendered his physician assistant certificate to the executive committee of the board on March 13, 1991 and proffered that he would not practice as a physician assistant pending resolution of the charges against him provided that the board would accept respondent's surrender in lieu of issuing an order for summary suspension.

On April 10, 1991, a settlement conference was held. Present were John F. Strahan, M.D., chief settlement officer; Frank A. Gunther, Jr.; Peter E. Dans, M.D.; and Lawrence A. Jones, M.D. Also present were respondent; Bernard A. Cook, counsel for respondent; Debra G. Woodruff, assistant attorney general; Charles F. Cichon, board investigator; and Barbara Hull Foster, board counsel. The settlement conference recommended that this case be resolved by entering into a consent order. The board, at its meeting on May 8, 1991, considered the settlement conference's recommendation and voted to accept this consent order.

Findings of fact

1. On February 20, 1985, the Board of Medical Examiners (BME) registered respondent as a certified physician assistant, Certification Number C00642.
2. On March 11, 1988, respondent submitted a physician assistant application for approval of job description to the BME. In the application, respondent indicated that he would be employed as a physician assistant exclusively at the Howard Medical Walk-in Clinic (the Howard Clinic), 8455 Baltimore National Pike, Ellicott City, Maryland. The named supervising physician was Chong C. Han,

M.D., and the alternate supervising physician was Donald J. Hayes, M.D. The job description stated that either physician would supervise respondent 70 to 80 percent of the time.

3. On March 17, 1988, BME approved respondent's job description at the Howard Clinic.
4. Sometime after March 17, 1988, Dr. Han began signing his name on blank prescriptions for respondent's use at the Howard Clinic.
5. On several occasions since April 1988, respondent removed boils or cysts from patients without physician supervision.
6. On several occasions since April 1988, respondent dispensed samples of prescription drugs to patients at the Howard Clinic.
7. In May 1989, Dr. Hayes terminated his relationship as respondent's alternative supervising physician.
8. From August 16, 1990 to sometime in October 1990, Dr. Han did not work at the Howard Clinic. Respondent did not notify the board about Dr. Han's absence. Respondent continued to treat patients at the Howard Clinic without physician supervision, in spite of the job description requirement that a named physician would supervise respondent 70 to 80 percent of the time.
9. Dr. Han returned to work at the Howard Clinic sometime in October 1990 on a part-time basis. Respondent continued to treat patients at the clinic when Dr. Han was not present and without physician supervision.
10. On or about February 12, 1990, respondent began treating patients and prescribing medications using prescriptions presigned by Dr. Han for patients who sought care at the Patapsco Medical Walk-in Clinic (the Patapsco Clinic), 3438 Annapolis Road, Baltimore, Maryland 21227.
11. Respondent has not submitted to the board an application for approval of job description listing the Patapsco Clinic as the facility where respondent intends to practice as a physician assistant.
12. Respondent was employed at the Patapsco Clinic as a physician assistant without a supervising physician.
13. On February 28, 1991, the board subpoenaed twenty-six medical records from the Patapsco Clinic. A review of the records revealed, that in the absence of physician supervision, respondent examined patients and prescribed medication on prescription forms presigned by Dr. Han in the following instances:

Date	Patient	DOB	Prescription
2/12/90	A	9/26/17	Phenobarbital Zaroxolyn Ampicillin Motrin
6/18/90	B	10/29/56	Kenolog Cream Benadryl
6/20/90	C	9/26/64	Motrin
7/20/90	A	9/26/17	Doxycycline Phenobarbital Zaroxolyn

Board of Physician Quality Assurance Actions

12/17/90	A	7/18/87	Tenormin Phenobarbital
1/28/91	D	7/18/87	Phenergan w/Codeine Alupent Syrup
1/28/91	E	7/12/50	Bactrim DS Pyridium
1/28/91	F	11/18/79	Augmentin Humibid LA
1/28/91	G	10/11/56	Pyridium
1/28/91	H	8/25/60	Cytocort Cream
1/28/91	I	11/1/66	Amoxicillin Humibid LA
1/28/91	J	2/3/80	Phenergan Expectorant EES
1/30/91	K	12/5/77	Humibid LA Amoxicillin
1/30/91	L	4/17/63	Entex Amoxicillin
2/4/91	H	8/25/60	Lotrim Cream
2/9/91	H	8/25/60	Atarax
2/11/91	H	8/25/60	Mycostatin

Conclusions of law

Based upon the findings of fact, the board concludes, as a matter of law, that respondent fraudulently or deceptively used a physician assistant certificate; performed delegated medical acts beyond the scope of the certificate not within a job description approved by the board; and performed delegated medical acts without the supervision of a physician. (See *Md. Health Occ. Code Ann.* §15-314(2), (4) and (5) (1991 Repl. Vol.).

Order

Based upon the foregoing, it is this 19th day of November 1991, by an affirmative vote of the majority of the full authorized membership of those members of the Board of Physician Quality Assurance of Maryland who considered this case,

ORDERED, that respondent's certification as a physician assistant is hereby **SUSPENDED** for a period of at least one year; and it is further

ORDERED, that one year from the date of this order, respondent may petition the board, through the settlement conference, for reinstatement of respondent's certification to practice as a physician assistant. At that time, respondent must submit evidence to show

1. how the Patapsco and Howard Medical Walk-in Clinics are being operated;
2. written attestation from any health professional working at the Patapsco and Howard Medical walk-in clinics that respondent did not work in the capacity as a health care provider during the previous year; and
3. evidence of continuing education courses taken during the year.

The board retains the authority to determine whether to grant or deny reinstatement of respondent's certificate.

NOTHING IN THIS ORDER SHALL BE CONSTRUED AS A PROMISE BY THE BOARD TO GRANT RESPONDENT'S APPLICATION FOR APPROVAL OF JOB DESCRIPTION; and it is further

ORDERED, if the board grants reinstatement of respondent's certificate, the board may place respondent on probation subject to the following probationary conditions and other conditions as the board deems necessary:

1. Respondent has signed releases, incorporated herein as Exhibit B, permitting the board to obtain information about respondent from any other relevant individuals or organizations as requested by the board.
2. Respondent must submit an application for approval of job description to the board as specified in HO §15-302.
3. Respondent may **ONLY** practice under the supervision of a licensed physician, approved by the board, on site 100 percent of the time.
4. Respondent's supervising physician must submit quarterly reports to the board about respondent's performance as a physician assistant, to be dated beginning August 15, 1992, November 15, 1992, February 15, 1993, and May 15, 1993.
5. After practicing under the supervision of a physician as specified in paragraph #3 above for a period of one year, respondent may petition the board, through the settlement conference, for a termination of all probationary conditions; and be it further

ORDERED, that respondent will be responsible for all costs incurred under this consent order; and be it further

ORDERED, that this consent order is considered a public document pursuant to *Md. State Gov't Code Ann.* §10-611, *et seq.* (1990 Cum. Supp.).

ISRAEL H. WEINER, M.D., Chairperson
Maryland Board of Physician Quality Assurance

Consent

By signing this consent, I hereby accept and agree to be bound by the foregoing consent order and its conditions and restrictions, consisting of nine pages.

1. By signing this consent, I hereby submit to this order and its conditions.
2. I acknowledge the validity of this order and the legal authority of the Board of Physician Quality Assurance to issue and enforce this order.
3. I acknowledge that by consent to this order, I am waiving my right to challenge in court the legal authority of the Board of Physician Quality Assurance to take action against my certificate to practice as a physician assistant in the state of Maryland.

I, S. Edward Bradford, P.A., have read this consent order and have carefully reviewed each and every part with my

Board of Physician Quality Assurance Actions

attorney, Patrick Malloy, Esquire. I understand it and voluntarily agree to it.

I sign and consent to this order after having an opportunity to consult with counsel and with full understanding of the meaning and terms of the order.

S. EDWARD BRADFORD, P.A.

Exhibit A

In the matter of
S. Edward Bradford, P.A.
before the
Maryland Board of
Physician Quality Assurance

Charges under the Maryland Medical Practice Act

Based on information received by the State Board of Physician Quality Assurance (the board), the board hereby charges S. Edward Bradford, P.A. (the respondent), under the Maryland Medical Practice Act (the act), *Md. Health Occ. Code Ann.* §15-314(2), (4), and (5) (1991 Repl. Vol.).

The pertinent provisions of §15-314 provide

Subject to the hearing provisions of §15-315 of this subtitle, the board, on the affirmative vote of a majority of its members then serving, may reprimand any certificate holder or suspend or revoke a certificate if the certificate holder

- (2) Fraudulently or deceptively uses a certificate;
- (4) Performs delegated medical acts beyond the scope of the certificate not within a job description approved by the board; and
- (5) Performs delegated medical acts without the supervision of a physician.

Allegations of fact.

The board bases its charges on the following facts that the board has cause to believe are true:

1. On February 20, 1985, the Board of Medical Examiners registered respondent as a certified physician assistant, Certification Number C00642.
2. On March 11, 1988, respondent submitted a physician assistant application for approval of job description to the Board of Medical Examiners. In the application, respondent indicated that he would be employed as a physician assistant exclusively at the Howard Medical Walk-in Clinic (the Howard Clinic), 8455 Baltimore National Pike, Ellicott City, Maryland. The named supervising physician was Chong C. Han, M.D., and the alternate supervising physician was Donald J. Hayes, M.D.
3. On March 17, 1988, the Board of Medical Examiners approved respondent's job description at the Howard Clinic.
4. Sometime after March 17, 1988, Dr. Han began signing his name on blank prescriptions for respondent's use at the Howard Clinic.
5. On several occasions since April 1988, respondent has been observed removing boils or cysts from patients without physician supervision.
6. On several occasions since April 1988, respondent has been observed treating patients at the Howard Clinic without physician supervision.
7. On several occasions since April 1988, respondent has been observed dispensing samples of prescription drugs to patients at the Howard Clinic.

8. In May 1989, Dr. Hayes terminated his relationship as respondent's alternate supervising physician.
9. From August 16, 1990 to sometime in October 1990, Dr. Han did not work at the Howard Clinic. Respondent did not notify the board about Dr. Han's absence. Respondent continued to treat patients at the Howard Clinic without physician supervision.
10. Dr. Han returned to work at the Howard Clinic sometime in October 1990 on a part-time basis. Although Dr. Han currently works at the Howard Clinic three days a week, the clinic is open six days a week. Respondent treats patients at the clinic when Dr. Han is not present and without physician supervision.
11. On or about February 12, 1990, respondent began treating patients and prescribing medications using prescriptions prescribed by Dr. Han for patients who sought care at the Patapsco Medical Walk-in Clinic (the Patapsco Clinic), 3438 Annapolis Road, Baltimore, Maryland 21227.
12. Respondent has not submitted to the board an application for approval of job description listing the Patapsco Clinic as the facility where respondent intends to practice as a physician assistant.
13. Respondent is currently employed at the Patapsco Clinic as a physician assistant without a supervising physician.
14. On February 28, 1991, the board subpoenaed twenty-six medical records from the Patapsco Clinic. A review of the records reveals that in the absence of physician supervision, respondent examined patients and prescribed medication on prescription forms prescribed by Dr. Han in the following instances:

Date	Patient	DOB	Drug prescribed
2/12/90	A	9/26/17	Phenobarbital Zaroxolyn Ampicillin Motrin
6/18/90	B	10/29/56	Kenolog Cream
6/20/90	C	9/26/64	Motrin
7/20/90	A	9/26/17	Doxycycline Phenobarbital Zaroxolyn
12/17/90	A	9/26/17	Tenormin Phenobarbital
1/28/91	D	7/18/87	Phenergan w/ codeine Alupent Syrup
1/28/81	E	7/12/50	Bactrim DS Pyridium
1/28/91	F	11/18/79	Augmentin Humibid LA
1/28/91	G	10/11/56	Pyridium
1/28/91	H	8/25/60	Cytocort Cream
1/28/91	I	11/1/66	Amoxicillin Humibid LA
1/28/91	J	2/3/80	Phenergan expectorant EES
1/30/91	K	12/5/77	Humibid LA Amoxicillin
1/30/91	L	4/17/63	Entex Amoxicillin
2/4/91	H	8/25/60	Lotrim cream
2/9/91	H	8/25/60	Atarax
2/11/91	H	8/25/60	Mycostatin

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Notice of possible sanctions

If, after a hearing, the board finds, by a preponderance of the evidence, that the respondent committed the prohibited acts as charged under *Md. Health Occ. Code Ann.* §15-314(2), (4), and (5) (1991 Repl. Vol.), the board may take disciplinary action against the respondent's certification, including revocation, suspension, or reprimand.

Notice of hearing, settlement conference, and prehearing conference

A hearing in this matter has been scheduled for April 16, 1991 at 9:00 a.m. in the Office of Administrative Hearings, Administrative Law Building, Greenspring Station, 10753 Falls Road, Lutherville, Maryland 21093.

In addition, a settlement conference in this matter has been scheduled for April 10, 1991 at 2:00 p.m. in the board's office, 4201 Patterson Avenue, Baltimore, Maryland 21215; and a prehearing conference in this matter has been scheduled for April 11, 1991 at 9:00 a.m. in the Office of Administrative Hearings, Administrative Law Building, Greenspring Station, 10753 Falls Road, Lutherville, Maryland 21093. The nature and purpose of the settlement conference and prehearing conference is described in the letter to the respondent.

ISRAEL H. WEINER, M.D., Chairperson
Maryland Board of Physician Quality Assurance

Exhibit B

In the matter of
S. Edward Bradford, P.A.
before the
Maryland Board of
Physician Quality Assurance

Summons and notice of charges and hearing

YOU ARE HEREBY SUMMONED to appear at a hearing before an administrative law judge. The administrative law judge refers proposed findings of fact, conclusions of law, and recommendations to the State Board of Physician Quality Assurance (the board) to determine whether you have committed the prohibited acts described in [Exhibit A] entitled "Charges under the Maryland Medical Practice Act" and what sanctions, if any, are appropriate.

The hearing is scheduled for April 16, 1991 at 9:00 a.m. in the Office of Administrative Hearings, Administrative Law Building, Greenspring Station, 10753 Falls Road, Lutherville, Maryland 21093.

This hearing is held under the authority of *Md. Health Occ. Code Ann.* Section 14-405 (1991 Replacement Volume) and *Md. State Gov't Code Ann.* Section 10-205 (1984).

If you do not appear as required by this summons, the administrative law judge may hear this matter in your absence and refer this matter to the board for disposition as provided under Section 14-405 of the Health Occupations Article.

ISRAEL H. WEINER, M.D., Chairperson
Maryland Board of Physician Quality Assurance



In the matter of
Charlie Davis, P.A.
before the
Maryland Board of
Physician Quality Assurance

Consent order

Based on information received by the State Board of Physician Quality Assurance (the board), the board, pursuant to its authority under *Md. Health Occ. Code Ann.* §15-314, charged Charlie Davis (the respondent), physician assistant (P.A.), under *Md. Health Occ. Code Ann.* §§15-314(2), (4), and (5) (1991 Repl. Vol.), on June 24, 1991.

The pertinent provisions of §15-314 provide

Subject to the hearing provisions of §15-315 of this subtitle, the board, on the affirmative vote of a majority of its members then serving, may reprimand any certificate holder or suspend or revoke a certificate if the certificate holder

- (2) Fraudulently or deceptively uses a certificate;
- (4) Performs delegated medical acts beyond the scope of the certificate not within a job description approved by the board; and
- (5) Performs delegated medical acts without the supervision of a physician.

On July 10, 1991, a settlement conference was held. Present were John F. Strahan, M.D., chief settlement officer; Frank A. Gunther, Jr.; and J. Andrew Sumner, M.D. Also present were respondent; Jerome M. Levine, counsel for respondent; Debra G. Woodruff, assistant attorney general; Sylvia J. Williams, legal assistant; Margaret T. Anzalone, deputy executive director; Charles F. Cichon, board investigator; Barbara Hull Foster, board counsel; Steven J. Poliakoff, staff attorney; and Laurie Slosberg, law clerk. The settlement conference recommended that this case be resolved by entering into a consent order. The board, at its meeting on September 25, 1991, considered the settlement conference's recommendation and voted to accept this consent order.

Findings of fact

1. On January 1, 1984, the Board of Medical Examiners (BME) registered respondent as a certified physician assistant.
2. On July 28, 1989, respondent submitted a physician assistant application for approval of job description to the board. In the application, respondent indicated that he would be employed as a physician assistant, on a part-time basis, at Howard Medical Walk-in Clinic (the Howard Clinic), 8455 Baltimore National Pike, Ellicott City, Maryland. The named supervising physician was Chong C. Han, M.D. The job description stated that Dr. Han would supervise respondent 80 percent of the time.
3. On August 16, 1989, the board approved respondent's job description at the Howard Clinic.

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4. On or about February 12, 1990, respondent began treating patients at the Patapsco Medical Walk-on Clinic (the Patapsco Clinic), 3438 Annapolis Road, Baltimore, Maryland 21227. Respondent did not submit a physician assistant application for approval of job description listing the Patapsco Clinic as a facility where respondent intended to practice as a physician assistant to the board. It is the responsibility of the physician assistant to insure that the application for approval of job description is submitted to the board.
5. Respondent was employed at the Patapsco Clinic as a physician assistant without a supervising physician.
6. While working as a physician assistant, respondent prescribed medications using prescriptions that were pre-signed by Dr. Han.
7. A physician may not delegate the duty of independently prescribing or dispensing drugs to a physician assistant. See COMAR 10.32.03.06(B).

Conclusions of law

Based upon the above findings of fact, the board concludes as a matter of law, that respondent fraudulently or deceptively used a physician assistant certificate; performed delegated medical acts beyond the scope of the certificate not within a job description approved by the board; and performed delegated medical acts without the supervision of a physician. (See *Md. Medical Occ. Code Ann.* §15-314(2), (4), and (5) (1991 Repl. Vol.).

Order

Based upon the foregoing, it is this 25th day of September 1991, by an affirmative vote of the majority of the full authorized membership of those members of the Board of Physician Quality Assurance of Maryland who considered this case,

ORDERED, that respondent is hereby REPRIMANDED; and it is further

ORDERED, that respondent may practice ONLY under the supervision of a licensed physician, approved by the board; and be it further

ORDERED, that respondent may NOT prescribe medications; and be it further

ORDERED, that respondent may NOT use prescriptions that are pre-signed; and be it further

ORDERED, that respondent will cooperate with the state, through its administrative prosecutors, in any action that involves the Howard and Patapsco clinics; and be it further

ORDERED, that this consent order is considered a public document pursuant to *Md. State Gov't. Code Ann.* §10-611, et seq. (1990 Cum. Supp.).

ISRAEL H. WEINER, M.D., Chairperson
Maryland Board of Physician Quality Assurance

Consent

By signing this consent, I hereby accept and agree to be bound by the foregoing consent order and its conditions and restrictions, consisting of nine (5) pages.

1. By signing this consent, I hereby submit to this order and its conditions.
2. I acknowledge the validity of this order and the legal authority of the Board of Physician Quality Assurance to issue and enforce this order.
3. I acknowledge that by consent to this order, I am waiving my right to challenge in court the legal authority of the Board of Physician Quality Assurance to take action against my certificate of practice as a physician assistant in the state of Maryland.

I, Charlie Davis, P.A., have read this consent order and have carefully reviewed each and every part with my attorney, Jerome M. Levine, Esquire. I understand it and voluntarily agree to it.

I sign and consent to this order after having an opportunity to consult with counsel and with full understanding of the meaning and terms of the order.

CHARLIE DAVIS, P.A.



In the matter of
Chong C. Han, M.D.
before the
Maryland Board of
Physician Quality Assurance
Consent order

Based on information received by the State Board of Physician Quality Assurance (the board), the board, pursuant to its authority under *Md. Health Occ. Code Ann.* §14-404, charged Chong C. Han, M.D. (the respondent), under the Maryland Medical Practice Act (the act), *Md. Health Occ. Code Ann.* §§14-404(a)(2) and (18) (1991 Repl. Vol.) on June 25, 1991.

The pertinent provisions of the act provide the following:

- (a) Subject to the hearing provisions of §14-405 of this subtitle, the board, on the affirmative vote of a majority of its full authorized membership, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:
 - (2) Fraudulently or deceptively uses a license;
 - (18) Practices medicine with an unauthorized person or aids an unauthorized person in the practice of medicine.

On July 10, 1991, a settlement conference was held. Present were John F. Strahan, M.D., chief settlement officer; Frank A. Gunther, Jr.; and J. Andrew Sumner, M.D. Also present were respondent, Daniel H. Scherr, counsel for respondent; Debra G. Woodruff, assistant attorney general;

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Sylvia J. Williams, legal assistant; Margaret T. Anzalone, deputy executive director; Charles F. Cichon, board investigator; Barbara Hull Foster, board counsel; Steven J. Poliakoff, staff attorney; and Laurie Slosberg, law clerk. The settlement conference recommended that this case be resolved by entering into a consent order. The board, at its meeting on September 25, 1991, considered the settlement conference's recommendation and voted to accept this consent order.

Findings of fact

1. At all times relevant to these charges, respondent was and is licensed to practice medicine in the state of Maryland.
2. On or about March 17, 1988, respondent was hired to work as a physician at the Howard Medical Walk-In Clinic (the Howard Clinic), 8455 Baltimore National Pike, Ellicott City, Maryland.
3. On March 18, 1988, the Board of Medical Examiners approved S. Edward Bradford's application for approval of job description to work as a physician assistant at the Howard Clinic under the supervision of respondent and Donald J. Hayes, M.D.
4. On April 16, 1989, the Board of Physician Quality Assurance approved Charlie Davis' application for approval of job description to work as a physician assistant at the Howard Clinic under respondent's supervision.
5. While employed at the Howard Clinic, respondent signed his name on blank prescriptions for the physician assistants to use. A physician may not delegate the duty of independently prescribing or dispensing drugs to a physician assistant. See COMAR 10.32.03.06(B).
6. Respondent had surgery in August 1990 and did not work at the Howard Clinic from August 16, 1990 to sometime in October 1990. Respondent did not notify the board about his absence. During that time, the physician assistant worked at the Howard Clinic without supervision.
7. On July 9, 1991, respondent terminated his employment at the Howard Clinic.
8. Respondent has cooperated fully with the board, the investigators, and the attorney general's office in the investigation of this matter.
9. Since 1985, respondent has been employed, on a part-time basis, by the Veterans Administration Regional Office (VA) in Baltimore, Maryland as a rating board medical specialist, a physician who performs medical chart reviews.
10. By presigning the prescription blanks with his signature, respondent enabled unauthorized persons to practice medicine.

Conclusions of law

Based upon the above findings of fact, the board concludes as a matter of law, that respondent aided unauthorized persons in the practice of medicine. See HO §14-404(a)(18).

Pursuant to HO §14-406(b), the board finds that there are no grounds for action under HO §14-404(a)(2) and hereby dismisses the charge.

Order

Based upon the foregoing findings of fact and conclusions of law, it is this 14th day of November 1991, by an affirmative vote of the majority of the full authorized membership of those members of the Board of Physician Quality Assurance who considered this case,

ORDERED, that respondent's license to practice medicine is **SUSPENDED**; and that the suspension shall be immediately **STAYED** and respondent is placed on **PROBATION** for one year from the effective date of this order, subject to the following conditions:

1. Respondent may continue to work as a rating board medical specialist at the Veterans Administration Regional Office and to work in any other position with the Veterans Administration that involves the review of medical records.
2. Except as provided in condition 1 above, respondent may not practice medicine in the state of Maryland.
3. Respondent may petition the conference to permit him to review medical records at a facility in addition to the Veterans Administration. Respondent shall inform the prospective employer of this consent order; the petition shall contain an affidavit signed by the prospective employer attesting to this disclosure.
4. Respondent may not prescribe medications, including controlled dangerous substances.
5. On or before November 1, 1991, respondent shall surrender to the board the following items:
 - a. Respondent's Maryland Controlled Dangerous Substance (CDS) Registration;
 - b. Respondent's United States Drug Enforcement Administration (DEA) Registration;
 - c. DEA Form 104, Voluntary Surrender of Controlled Substances Privileges;
 - d. Any DEA order forms for controlled dangerous substances; and
 - e. All prescription blanks in respondent's possession or control.
6. Respondent will cooperate with the state, through its administrative prosecutors, in any action that involves the Howard and Patapsco Clinics; and be it further

ORDERED, that the board shall order a peer review of respondent's practice at the Howard Medical Walk-in Clinic. The peer reviewers will conduct a chart review and interview respondent; and be it further

ORDERED, that after one year after the effective date of this ORDER, respondent may petition the board for reinstatement of his license without any conditions or restrictions. Respondent shall have the burden of proving to the board's

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satisfaction that he is competent to practice medicine. The board may require respondent to

1. Take and pass the Special Purpose Examination with a score of at least 75.
2. Correct any deficiencies identified by the Peer Review Management Committee.
3. Submit to an evaluation for clinical competence.

The board reserves the right to consider respondent's moral character in evaluating the petition; and be it further

ORDERED, that if the board has probable cause to believe that respondent has violated a condition of this order, or that respondent has violated the Maryland Medical Practice Act, or that respondent presents a danger to the public health, safety, or welfare, the board, WITHOUT PRIOR NOTICE AND AN OPPORTUNITY FOR A HEARING, MAY VACATE THE STAY OF SUSPENSION AND REINSTATE THE SUSPENSION, provided that respondent is given notice of the board's action and an opportunity for a hearing within thirty days after respondent requests a hearing; and be it further

ORDERED, that this consent order is considered a public document pursuant to *Md. State Gov't. Code Ann.* §10-611, *et seq.* (1990 Cum. Supp.).

ISRAEL H. WEINER, M.D., Chairperson
Maryland Board of Physician Quality Assurance

Consent

By signing this consent, I hereby accept and agree to be bound by the foregoing consent order and its conditions and restrictions, consisting of eight pages.

1. By signing this consent, I hereby submit to this order and its conditions.
2. I acknowledge the validity of this order and the legal authority of the Board of Physician Quality Assurance to issue and enforce this order.
3. I acknowledge that by consent to this order, I am waiving my right to challenge in court the legal authority of the Board of Physician Quality Assurance to take action against my license of practice as a physician in the state of Maryland.

I, Chong C. Han, M.D., have read this consent order and have carefully reviewed each and every part with my attorney, Daniel H. Scherr, Esquire. I understand it and voluntarily agree to it.

I sign and consent to this order after having an opportunity to consult with counsel and with full understanding of the meaning and terms of the order.

CHONG C. HAN, M.D.



In the matter of
Else M. Hillgard, M.D.
before the
Maryland Board of
Physician Quality Assurance
Order for summary suspension of
license to practice medicine

The State Board of Physician Quality Assurance (the board) herein sets forth the following background information as pertinent to this order for summary suspension (the emergency suspension) with regard to the license of Else M. Hillgard, M.D. (the respondent) to practice medicine in the state of Maryland:

1. Respondent is a physician licensed to practice medicine in the state of Maryland.
2. On October 23, 1991, the board voted to summarily suspend respondent's license to practice medicine in Maryland.
3. The Board's determination to summarily suspend respondent's license was based upon the following information:
 - a. In December 1988, the Board of Physician Quality Assurance received information that respondent was prescribing controlled substances for Patient A, a drug abuser. Respondent began treating Patient A on October 25, 1988 for "anxiety disorder depression." The patient had a history of drug abuse. On November 1, 1988, Patient A was admitted to Maryland General Hospital for a drug overdose. Respondent discovered that the patient was on Methadone but continued to prescribe the following drugs:

Date	Drug	Quantity
10/25/88	Ativan 2 mg	30
	Phenergan 25 mg	60
10/26/88	Phenergan 25 mg	30
	Ativan 2 mg	30
	Prozac 20 mg	10
	Propranolol 20 mg	50
	Phenergan 25 mg	30
10/31/88	Ativan 2 mg	50
	Orazepam 2 mg	60
11/10/88	Phenergan 25 mg	50
1/9/89	Xanax 1 mg	50
	Xanax 1 mg	30
1/28/89	Phenergan 25 mg	30
	APAP #4/Codeine	20
	Xanax	30
2/7/89	APAP #4/Codeine	50
2/11/89	Xanax 1 mg	60
2/14/89	Xanax 1 mg	30
	Phenergan 25 mg	50
	APAP #4/Codeine	30
2/21/89	Xanax 1 mg	30
2/27/89	Xanax 1 mg	30
	Propoxyphene 65 mg	100
	Phenergan 50 mg	50
3/07/89	Xanax 1 mg	30
3/14/89	Xanax 1 mg	60

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	Phenergan 25 mg	60
5/03/89	Oxycodone/ASA	50
5/06/89	Oxycodone/ASA	30
	Diazepam 10 mg	30
5/16/89	Oxycodone/ASA	50

It is below the standard of care for respondent to prescribe medication for a patient who the respondent knows is enrolled in a Methadone program in the absence of consultation or coordination with the treating physician in the Methadone program. The treating physician in the Methadone program is responsible for prescribing medications.

It is a common practice among drug abusers to use Phenergan to enhance the effects of other drugs. A review of the patient's chart fails to reveal why respondent prescribed Phenergan. It is below the standard of care to prescribe Phenergan without indication.

In addition, respondent failed to assess the efficacy of prescribing Ativan and Xanax for this patient. It is below the standard of care to prescribe benzodiazepines for six months without monitoring the patient's response.

- b. In 1989, the United States Drug Enforcement Administration (DEA) investigated respondent's prescribing practices at three pharmacies in the area where respondent maintained an office. The investigation revealed that respondent wrote forty-five prescriptions for Patient B from January 1, 1989 to July 7, 1989 for the following controlled substances:

Number of Prescriptions	Drug	Quantity
14	Valium 10 mg	839
11	Oxycodone	430
7	Percodan	250
6	Halcion 0.25 mg	200
4	Propoxyphene 65 mg	310
1	Phenobarbital 30 mg	30
1	Nembutal 100 mg	15
1	Tussend Expectorant	8 oz

- c. During a nineteen-day period from January 12, 1989 to January 31, 1989, respondent wrote prescriptions for Patient B for 464 tablets of the following controlled substances

Number of Prescriptions	Drug	Quantity
2	Valium	144
3	Percodan	110
2	Halcion 0.25 mg	90
1	Propoxyphene 65 mg	100
1	Oxycodone/ASA	20

- d. The DEA investigation also revealed that respondent wrote thirty-seven prescriptions for Patient C from January 1, 1989 to July 7, 1989 for the following drugs:

Number of Prescriptions	Drug	Quantity
5	APAP No. 4/Codeine	210
7	Seconal 100 mg	165
5	Ativan 2 mg	250
6	Tylenol No. 4	240
6	Lorazepam 2 mg	400
1	Darvocet N100	50
1	Propoxyphene N/APAP	50
5	Clonidine 3 mg	350
1	Chloral Hydrate 500 mg	16

It is a common practice among drug abusers to use Clonidine to enhance the effects of other drugs.

A subsequent peer review of Patient C's medical records found that respondent attempted "to treat [the] addiction with more addictive, but legal medication. No evidence that this is an effective treatment." The peer reviewer concluded that this was "not an accepted treatment in psychiatry."

- e. As a result of the DEA investigation, respondent surrendered DEA permit #AH8248153 on July 25, 1989.
f. On June 27, 1990, the Medical and Chirurgical Faculty (Med Chi) Committee on Drugs reported to the board that "there is evidence of substandard care with regard to [respondent's] prescribing practices." According to the peer review, respondent failed to provide care within the standard of care to the following patients:

Patient D. (DOB 12/11/53). Dx: Addiction Personality. Respondent prescribed medications on a monthly basis from 10/10/87 to 12/24/88 without coordinating the patient's care with the primary care physician. There was no reason for respondent, as the patient's psychiatrist, to prescribe these medications.

Patient E. (DOB 11/11/53). Dx: Addiction Personality. Respondent prescribed barbiturates to this patient despite the patient's desire to be drug free in order to pursue career goals.

Patient F. (DOB 1/24/53). Dx: Addiction Personality. Respondent attempted to treated the patient's addiction with addictive medication.

Patient G. (DOB 4/24/55). Dx: Addiction Personality. This patient saw an internist for primary care. Respondent prescribed medications without coordinating the patient's care with the primary care physician. Respondent may have addicted the patient. According to the patient's chart, respondent prescribed the following drugs:

Date	Drug	Quantity
10/23/87	Xanax 1 mg	60
	Premarin 1.25 mg	100
	Phenergan with Codeine	
11/6/87	Xanax 1 mg	100
12/3/87	Xanax	100

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	Timoptic Ophthalmic	15 cc
	Premarin 1.25 mg	30
	Phenergan with Codeine	16 oz
	Lidex 5%	120 ml
1/26/88	Xanax 1 mg	60
	Lidex 5%	120 ml
	Timoptic Ophthalmic	15 cc
	Premarin 1.25 mg	30
	Ambenyl	
	Keflex	100
2/22/88	Xanax 1 mg	60
	Premarin 1.25 mg	30
	Phenergan with Codeine	8 oz
	Ampicillin 250 mg	100
	Oscal	
3/14/88	Xanax 1 mg	80
	Phenergan with Codeine	16 oz
4/16/88	Timoptic 0.5%	15 cc
	Xanax 1 mg	50
	Phenergan with Codeine	6 oz
	Oscal	100
4/28/88	Xanax 1 mg	56
	Phenergan with Codeine	16 oz
	Potassium Chloride	16 oz
6/21/88	Xanax 1 mg	56
	Phenergan with Codeine	
	Premarin 1.25 mg	30
	Lidex 5%	120
	Percodan	10
7/19/88	Xanax 2 mg	56
	Premarin	
8/2/88	Xanax	
	Premarin	
9/7/88	Xanax 1 mg	
	Phenergan with Codeine	
9/20/88	Timoptic 0.5%	15 cc
	Phenergan with Codeine	16 oz
	Xanax 1 mg	60
10/18/88	Xanax 1 mg	60
	Phenergan with Codeine	16 oz
10/29/88	Phenergan with Codeine	8 oz
	Clonidine	60
	Tylenol #4	50
11/1/88	Xanax 1 mg	60
	Phenergan with Codeine	16 oz
	Tylenol #4	60
	Clonidine 1 mg	60
	Premarin 1.25 mg	30
11/29/88	Xanax 1 mg	60
	Premarin 1.25 mg	30
	Tylenol #4	60
	Phenergan with Codeine	16 oz
12/13/88	Xanax	
	Phenergan with Codeine	16 oz
	Tylenol #4	60
	Lidex	
	Premarin 1.25 mg	30
1/17/89	Berocca Plus	30
	Phenergan with Codeine	16 oz
	Xanax	50
2/14/89	Phenergan with Codeine	
	Tylenol #4	30

Patient H. (DOB 11/10/50). The progress notes reveal that despite respondent's suspicions that the patient was an addict, respondent continued to pre-scribe addictive drugs. It is below the standard of care to prescribe addictive drugs to a patient who respondent suspected was a drug addict. According to the patient's chart, respondent prescribed the following drugs:

Date	Drug	Quantity
4/5/89	Valium 10 mg	50
	Xanax 0.5 mg	50
	Placidyl 500 mg	15
	Tylox	100
4/18/89	Xanax 0.25 mg	60
	Valium 10 mg	60
	Placidyl 500 mg	15
	Percodan	50
4/22/89	Xanax 0.25 mg	50
	Valium 10 mg	60
	Placidyl 750 mg	15
	Tylox	60
	Imipramine 50 mg	30
5/4/89	Placidyl 500 mg	50
	Imipramine 50 mg	100
	Tylox	60
	Valium 10 mg	60
	Preludin 75 mg	30
	Xanax 0.25 mg	50
5/17/89	Placidyl 50 mg	30
	Valium 10 mg	60
	Tylox	60
6/2/89	Placidyl 50 mg	30
	Valium 10 mg	60
	Tylox	60
	Berocca Plus	30
6/9/89	Imipramine 50 mg	30
	Phenergan 25 mg	100
6/16/89	Valium	
	Tylox	
	Placidyl	
6/23/89	Valium	
	Tylox	
	Placidyl	
	Imipramine	
	Phenergan 25 mg	100

Patient I. (DOB 9/19/58). The peer review found that respondent's practice of prescribing barbiturates to this patient was below the standard of care. According to the patient's chart, respondent prescribed the following drugs:

Date	Drug	Quantity
2/14/89	Sinequan 50	30
	Centrax 10 mg	30
	Halcion 0.25 mg	20
2/21/89	Xanax 1 mg	50
	Nembutal 50 mg	30
3/8/89	Surmontil	50
3/24/89	Surmontil 50 mg	100
	Seconal 100 mg	30

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	Xanax 1 mg	100
3/27/89	Surmontil 50 mg	100
	Seconal 100 mg	20
	Xanax 1 mg	60
4/4/89	Xanax 1 mg	50
	Seconal 100 mg	50
4/26/89	Xanax 1 mg	75
	Seconal 100 mg	20
6/1/89	Seconal 100 mg	50
	Surmontil	
	Xanax 1 mg	100

Patient J. The peer review found that respondent's practice of prescribing barbiturates was below the standard of care. According to the patient's chart, respondent prescribed the following drugs:

Date	Drug	Quantity
1/4/89	Ativan 2 mg	100
1/8/89	Nembutal 50 mg	20
1/18/89	Nembutal 50 mg	20
	Ativan 2 mg	50
2/2/89	Nembutal 50 mg	30
	Ativan 1 mg	50
2/18/89	Nembutal 50 mg	30
	Ativan 2 mg	100
3/24/89	Nembutal 100 mg	30
	Ativan 2 mg	100
	Ativan 2 mg	100
5/6/89	Nembutal 100 mg	30
	Percocet 100	100
	Ativan	60
6/23/89	Nembutal 100 mg	30

- g. On June 22, 1990, respondent signed a memorandum of agreement with the DEA which granted respondent a certificate of registration to prescribe only Schedule II non-narcotic and Schedule IV drugs. As a condition of registration, respondent agreed to submit a list of all controlled substances she prescribed, administered, or dispensed on a quarterly basis for two years from the date of issuance of the certificate of registration.
4. Beginning in September 1990, the Medical Care Compliance Administration (MCCA) of the state of Maryland Department of Health and Mental Hygiene received numerous phone calls from pharmacists who reported that known drug addicts were presenting Medical Assistance prescriptions written by respondent for Phenergan. It is a common practice among drug abusers to use Phenergan to enhance the effects of abusable drugs.
5. As a result of the information described in paragraph 4 above, MCCA audited all Medical Assistance prescriptions written by respondent for scheduled drugs and submitted for payment from September 1990 through January 1991. The audit revealed that respondent wrote 248 prescriptions using Medical Assistance forms during that time period. Of the 248 prescriptions, thirty-one were written for Phenergan. A review of all Medical Assistance prescriptions written by respondent for scheduled

drugs and submitted for payment from September 1990 to September 1991 indicates that respondent continues to overprescribe scheduled drugs in amounts far exceeding the recommended therapeutic dose.

6. The information received by the board demonstrates that respondent is not practicing in accordance with the accepted standards of a psychiatrist. In particular, recent information obtained from MCCA about respondent's prescribing practices as described in the findings of fact below support the board's finding that the public health, safety, and welfare imperatively requires emergency action.

Findings of fact

- Based upon all the information received by the board in connection with its investigation and including, but not limited to, the background information set forth above and incorporated herein, and the instances described in paragraph 2 below, the board has reason to believe that the following facts are true:
- Respondent's practice of prescribing drugs in amounts exceeding the recommended therapeutic dose demonstrates a failure to meet the standard of care and indicates that respondent is prescribing drugs for illegal or illegitimate medical purposes in the following instances:
 - A review of Medical Assistance prescriptions written for Patient K and submitted for payment to Medical Assistance reveal that respondent wrote the following prescriptions:

Date	Drug	Quantity
2/13/91	Phenergan 50 mg	100
2/27/91	Phenergan 50 mg	60
3/11/91	Ativan 2 mg	60
3/11/91	Phenergan 50 mg	100
3/21/91	Ativan 2 mg	60
3/26/91	Ativan 2 mg	60
4/1/91	Ativan 2 mg	30
4/1/91	Ativan 2 mg	30
4/1/91	Phenergan 50 mg	60
4/17/91	Ativan 2 mg	56
4/25/91	Phenergan 50 mg	50
4/25/91	Ativan 2 mg	50

Prescribing 346 Ativan 2 mg in forty-six days yields approximately 15 mg/day and far exceeds the recommended therapeutic dose of 2 to 6 mg/day.

Since Phenergan potentiates the effect of Ativan, the concomitant prescribing of large amounts of Ativan and Phenergan poses a serious risk to the patient. Simultaneous use of two drugs without appropriate consideration of their possible interaction is an example of inappropriate prescribing that may jeopardize the patient's health.

- A review of Medical Assistance prescriptions written for Patient L and submitted for payment to Medical Assistance reveal that respondent wrote the following prescriptions:

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Date	Drug	Quantity
2/13/91	Ativan 2 mg	10
2/21/91	Ativan 2 mg	30
2/21/91	Ativan 2 mg	30
2/27/91	Phenergan 50 mg	100
3/4/91	Ativan 2 mg	50
3/11/91	Ativan 2 mg	60
3/23/91	Xanax 1 mg	60
3/25/91	Xanax 1 mg	30
4/1/91	Xanax 1 mg	60
4/1/91	Xanax 1 mg	60
4/1/91	Phenergan 50 mg	100
4/17/91	Pamelor 25 mg	100
4/17/91	Xanax 1 mg	30
4/25/91	Xanax 1 mg	30
4/29/91	Xanax 1 mg	30

Prescribing 180 Ativan 2 mg in twenty-six days exceeds the recommended therapeutic dose. Prescribing 360 Xanax 1 mg in thirty-seven days exceeds the maximum recommended therapeutic dose.

Phenergan potentiates the effects of Ativan and Xanax. Prescribing Ativan and Xanax in amounts exceeding the recommended therapeutic dose with Phenergan endangers the patient's health.

In addition, prescribing Pamelor, an antidepressant with Xanax, an anxiolytic, may cause respiratory depression.

- c. A review of Medical Assistance prescriptions written for Patient M and submitted for payment to Medical Assistance reveal that respondent wrote the following prescriptions:

Date	Drug	Quantity
4/8/91	Xanax 1 mg	30
4/11/91	Xanax 1 mg	30
4/15/91	Xanax 1 mg	50
4/20/91	Xanax 1 mg	50
5/1/91	Xanax 1 mg	35
5/9/91	Xanax 1 mg	60
5/13/91	Xanax 1 mg	50
5/23/91	Xanax 1 mg	30
5/24/91	Xanax 1 mg	30
5/27/91	Xanax 1 mg	50
5/28/91	Xanax 1 mg	50
6/1/91	Xanax 1 mg	50
6/3/91	Xanax 1 mg	50
6/10/91	Xanax 1 mg	50
6/12/91	Xanax 1 mg	60
6/18/91	Xanax 1 mg	60

Prescribing 735 Xanax 1 mg in seventy-one days yields approximately 10/day. The recommended maximum total daily dose is 4 mg. The amount of Xanax that respondent prescribed for Patient M far exceeds the maximum recommended therapeutic dose and jeopardizes the patient's health.

- d. A review of Medical Assistance prescriptions written for Patient N and submitted for payment to Medical Assistance reveal that respondent wrote the following prescriptions:

Date	Drug	Quantity
4/24/91	Valium 10 mg	10
5/1/91	Valium 10 mg	30
5/8/91	Valium 10 mg	50
5/15/91	Valium 10 mg	60
6/6/91	Valium 10 mg	60
6/12/91	Valium 10 mg	50

Prescribing 260 Valium 10 mg in forty-nine days yields approximately 5/day and exceeds the maximum recommended daily dose.

- e. A review of Medical Assistance prescriptions written for Patient O and submitted for payment to Medical Assistance reveal that respondent wrote the following prescriptions:

Date	Drug	Quantity
6/24/91	Xanax 1 mg	20
6/25/91	Xanax 1 mg	30
6/28/91	Xanax 1 mg	60

Prescribing 110 Xanax 1 mg in four days yields approximately 27.5/day which far exceeds the recommended maximum total daily dose of 4 mg. The excessive amount of Xanax that respondent prescribed for Patient O in four days demonstrates that the patient is either abusing the drug or diverting the drug for illegal or illegitimate medical purposes.

- f. A review of Medical Assistance prescriptions written for Patient P and submitted for payment to Medical Assistance reveal that respondent wrote the following prescriptions:

Date	Drug	Quantity
7/16/91	Xanax 1 mg	50
7/23/91	Xanax 1 mg	50
8/05/91	Xanax 1 mg	50
8/19/91	Xanax 1 mg	50
9/3/91	Xanax 1 mg	50
9/4/91	Xanax 1 mg	50
9/13/91	Xanax 1 mg	50

Prescribing 350 Xanax 1 mg in fifty-nine days yields approximately 6/day and exceeds the recommended maximum total daily dose.

- g. A review of Medical Assistance prescriptions written for Patient Q and submitted for payment to Medical Assistance reveal that respondent wrote the following prescriptions:

Date	Drug	Quantity
8/16/91	Xanax 1 mg	60
8/30/91	Xanax 1 mg	70
8/30/91	Xanax 1 mg	70
3/30/91	Xanax 1 mg	70
9/3/91	Xanax 1 mg	70
9/6/91	Xanax 1 mg	70
9/11/91	Xanax 1 mg	70
9/24/91	Xanax 1 mg	70

Prescribing 550 Xanax 1 mg in thirty-nine days yields approximately 14/day and exceeds the recommended maximum total daily dose of 4 mg. The

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amount of Xanax that respondent prescribed for Patient Q endangered the patient's health.

3. Respondent's practice of prescribing Ativan, Xanax, and Valium to patients K, L, M, N, O, P, and Q from February 13, 1991 through September 24, 1991 indicates that respondent continues to abuse her privilege of writing prescriptions by overprescribing and may be contributing to drug diversion. Respondent's pattern of overprescribing Ativan, Xanax, and Valium poses an immediate threat to the public health, safety, and welfare. In addition, respondent's prescribing of Phenergan and Pamelor in conjunction with benzodiazepines indicates a failure to recognize the potentially dangerous interaction of the various drugs.
4. On October 17, 1991 at 12:00 p.m., respondent was notified of the board's decision to summarily suspend her license and was given an opportunity to appear at the board meeting on October 23, 1991 to show cause why the board should not execute the order for summary suspension.
5. Respondent's retention of a license to practice medicine in Maryland and her ability to continue to treat patients poses a grave risk and an imminent danger to the public health, safety, and welfare of the citizens of the state of Maryland.
6. Based upon the above information, the board has reason to believe that respondent has violated *Md. Health Occ. Ann.* §14-404(a)(22) and (28) (1991 Repl. Vol.).

The pertinent provisions of §14-404(a) provide

- (a) Subject to the hearing provisions of §14-405 of this subtitle, the board, on the affirmative vote of a majority of its full authorized membership, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee
- (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this state;
- (28) Sells, prescribes, gives away, or administers drugs for illegal or illegal or illegitimate medical purposes.

Conclusions of law

Based upon the foregoing facts, the board finds that the public health, safety, and welfare imperatively require emergency action in this case, pursuant to *Md. State Gov't Code Ann.* §10-405(b) (1984).

Order

It is this 23rd day of October 1991 by the State Board of Physician Quality Assurance

ORDERED, that pursuant to the authority vested in the board by *Md. State Gov't. Code Ann.* §10-405(b) (1984), respondent's license to practice medicine in the state of Maryland is hereby SUMMARILY SUSPENDED; and be it further

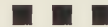
ORDERED, that, upon request by respondent, a hearing to consider this summary suspension will be held at the Office of Administrative Hearings, Administrative Law Building, Greenspring Station, 10753 Falls Road, Lutherville, Maryland 21093 on Wednesday, November 20, 1991 at 9:00 a.m.; and be it further

ORDERED, that on presentation of this order, respondent shall surrender to the board's investigator the following items:

- (1) her original Maryland license from the Board of Medical Examiners;
- (2) the renewal card of her license to practice medicine from the Board of Physician Quality Assurance;
- (3) DEA Certificate of Registration Number BH2412687;
- (4) Maryland Controlled Dangerous Substances Registration Certificate Number M10194;
- (5) all Medical Assistance prescription forms; and
- (6) any prescription pads on which her name and DEA number are imprinted; and be it further

ORDERED, that a copy of this order shall be filled with the board in accordance with *Md. Health Occ. Code Ann.* §14-407 (1991 Repl. Vol.).

ISRAEL H. WEINER, M.D., Chairperson
Maryland Board of Physician Quality Assurance



In the matter of
Edward O. Hunt, Jr., M.D.
before the
Maryland Board of
Physician Quality Assurance
Order reinstating license.

By order (Appendix A) dated July 2, 1991, the Board of Physician Quality Assurance (the board) found Edward O. Hunt, Jr., M.D. (the respondent) guilty of committing a prohibited act as set forth in Health Occupations Article, §14-404(b). The order provides that on August 1, 1991, if the respondent demonstrates to the board's satisfaction that respondent had complied with the terms and conditions of the July 2, 1991 order, the board would entertain a petition for reinstatement of the respondent's license to practice medicine. By letter dated August 5, 1991, respondent petitioned the board for reinstatement of his license (petition) to practice medicine in Maryland. At its meeting on August 14, 1991, the board, through its settlement conference (the conference) reviewed respondent's petition. Based upon the board's review of the petition, the board determined that respondent had fulfilled the conditions contained in the 1991 order.

Findings of fact

Based on the information known and available to it, the board finds that respondent had developed a plan to take the

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additional twenty-five hours of Category 1 continuing medical education.

Conclusions of law

The board concludes, as a matter of law, that respondent has satisfactorily complied with the condition set forth in the order of July 2, 1991.

Order

Upon the foregoing findings of fact and conclusions of law, it is this 4th day of September 1991, by a majority vote of the full authorized membership of the board.

ORDERED, that effective as of the date of this order, the sanction of revocation imposed upon respondent's practice of medicine by the board's July 1991 order is hereby STAYED; and be it further

ORDERED, that respondent's license to practice medicine in the state of Maryland be REINSTATED; and be it further

ORDERED, that respondent is placed on probation subject to the following conditions:

1. Respondent shall be required to take an additional twenty-five hours of Category 1 continuing medical education in the field of family practice in addition to the continuing education requirements for renewal; and
2. Respondent will practice medicine according to the laws of Maryland; and be it further

ORDERED, that THREE YEARS AFTER THE EFFECTIVE DATE OF THIS ORDER, the board will entertain a petition for termination of respondent's probationary status and reinstatement of respondent's license to practice medicine in the state of Maryland without any conditions or restrictions whatsoever. If the respondent has complied with all conditions of probation and if there are no outstanding complaints against respondent, the board will reinstate the respondent's license without any conditions or restrictions whatsoever; and be it further

ORDERED, that this is a final order and as such is considered a public document pursuant to the Maryland Public Information Article, State Government Article, *Annotated Code of Maryland*, §§10-611 *et seq.*, specifically §10-617(h)(2)(vi).

ISRAEL H. WEINER, M.D., Chairperson
Maryland Board of Physician Quality Assurance

Appendix A

In the matter of
Edward O. Hunt, Jr., M.D.
before the
Maryland Board of
Physician Quality Assurance

Final decision

On October 11, 1990, the Board of Physician Quality Assurance (the board) issued charges against Edward O. Hunt, Jr., M.D. (the respondent). Specifically, the board charged respondent under

the Maryland Medical Practice Act (the act), *Md. Health Occ. Code Ann.*, §14-404(b) which states

(b) Crimes involving moral turpitude.

- (1) Subject to the Administrative Procedure Act, the board shall order the suspension of a license if the licensee is convicted of or pleads guilty or *nolo contendere* with respect to a crime involving moral turpitude, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside.
- (2) After completion of the appellate process if the conviction has not been reversed or the plea has not been set aside with respect to a crime involving moral turpitude, the board shall order the revocation of a license subject to the hearing provisions of §14-405.

A hearing was held on January 22, 1991 before an administrative law judge (ALJ). Present at the hearing were the respondent, Edward O. Hunt, Jr., M.D.; the respondent's counsel, Emanuel Levin, Esquire; Ruth and Susan Hunt, wife and daughter of respondent; Robert J. Gilbert, assistant attorney general, administrative prosecutor, and the ALJ.

At the hearing, the state introduced the following evidence:

State exhibit A. Indictment and docketing entries.

State exhibit B. Official transcript of proceedings.

The respondent introduced the following evidence:

Respondent exhibit A. Letters and documents in mitigation.

Respondent exhibit B. Motion for modification of sentence.

The following witness testified for respondent: Katie Grove.

After the hearing was adjourned, respondent's counsel sought and was granted a delay in rendering an opinion because of the pendency of a request for modification in the circuit court. The court subsequently issued its order modifying the earlier results to probation before judgment (PBJ).

On May 1, 1991, the ALJ filed a recommended decision notifying the parties of their right to file exceptions and request oral argument. The parties did not file exceptions or request oral argument. The board notified the parties on May 31, 1991, that it would consider the ALJ's recommended decision and issue a final decision. The parties were notified of their right to file exceptions and make oral argument. Mr. Levin requested that he make oral argument but filed no exceptions. The state neither filed exceptions nor requested oral argument. At its meeting on Wednesday, June 26, 1991, the board considered respondent's. By a majority of its full authorized membership, the board voted to issue the following decision.

Findings of fact

By clear and convincing evidence, the board finds that

1. At all times relevant to these charges, the respondent was and is licensed to practice medicine in the state of Maryland.
2. On or about April 20, 1990, the respondent was indicted by the Grand Jury for Baltimore City, under indictment number 19011020, for the charge of theft over three hundred dollars.
3. On or about May 30, 1990, in the Circuit Court for Baltimore City, part 21, the respondent pleaded guilty to the aforementioned charge.
4. On or about July 11, 1990, as a result of the guilty plea in indictment number 19011020, the respondent was sentenced to a term incarceration of two years, which was suspended in favor of a period of supervised probation of two years. The respondent was further ordered to pay restitution in the amount of \$6,256.23;

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to perform four hundred hours of community service and to pay the costs of the court.

5. The crime of theft over three hundred dollars as described in paragraphs two, three, and four, is a crime involving moral turpitude under the act.
6. The respondent did not file an application for leave to appeal to the Court of Special Appeals within the time required by Md. Rule §8-204.
7. The special circumstances in this case are that the crime of which respondent is convicted include no theft of monies for patient care.
8. According to respondent, he was unaware that by pleading guilty to this crime that his license would be automatically revoked.

Conclusions of law

Based upon the foregoing findings of fact, the board concludes as a matter of law that respondent follows under the mandate of HO §14-404(b), which provides

(b) Crimes involving moral turpitude.

- (1) Subject to the Administrative Procedure Act, the board shall order the suspension of a license if the licensee is convicted of or pleads guilty or *nolo contendere* with respect to a crime involving moral turpitude, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside.
- (2) After completion of the appellate process if the conviction has not been reversed or the plea has not been set aside with respect to a crime involving moral turpitude, the board shall order the revocation of a license subject to the hearing provisions of §14-405.

Order

Based upon the foregoing findings of fact and conclusions of law as mandated by Health Occupations Article, §14-404(b), it is this 2nd day of July 1991

ORDERED, that the respondent's license to practice medicine be REVOKED; and be it further

ORDERED, that on August 1, 1991, respondent can submit a petition to the board for reinstatement of his license if he has a plan for taking an additional twenty-five hours of Category 1 continuing medical education; and be it further

ORDERED, that if respondent submits such petition, respondent will be scheduled to appear at the board's settlement conference (conference) on Wednesday, August 14, 1991 at which time the conference may stay the revocation of his license and enter into a consent order wherein respondent is placed on probation for three years subject to certain conditions; and be it further

ORDERED, that if respondent submits a plan whereby he will take an additional twenty-five hours of Category 1 continuing medical education in the field of family practice which is satisfactory to the conference, these hours will be in addition to the continuing education requirements for renewal; and be it further

ORDERED, that this is a final order and as such is considered a public document pursuant to State Government Article, *Annotated Code of Maryland*, §10-611 *et seq.*

ISRAEL H. WEINER, M.D., Chairperson
Maryland Board of Physician Quality Assurance

In the matter of
Thomas A. Pittman, M.D.
before the
Maryland Board of
Physician Quality Assurance

Dear Dr. Weiner and members of the board:

Please be advised that I have decided to surrender my license to practice medicine in Maryland. I understand that I may apply for reinstatement of my license after I meet certain requirements which are described in this letter of surrender. Therefore, my decision to surrender my license is REVOCABLE.

I understand that this letter of surrender will be considered a PUBLIC document.

On May 8, 1991, the Board of Physician Quality Assurance (the board) voted to summarily suspend my medical license and charge me pursuant to *Md. Health Occ. Code Ann.* §14-404(a)(4) (1991 Replacement Volume). Section 14-404(a)(4) provides in pertinent part:

Subject to the hearing provisions of §14-405 of this subtitle, the board, on the affirmative vote of a majority of its full authorized membership, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:

(4) Is professionally, physically, or mentally incompetent.

The board also voted that if I surrendered my license it would not proceed to issue either the charges or the summary suspension. Prior to the issuance of charges against me, I advised my attorney, Philip Sturman, Esquire, and the board, that I wished to voluntarily surrender my license to the board. Consequently, my decision to surrender my license will result in the board's rescinding its vote to charge me and summarily suspend my license.

My decision to surrender my license and discontinue the practice of medicine has been prompted by my desire to avoid being charged under the Maryland Medical Practice Act, *Md. Health Occ. Code Ann.* §14-404 (1991 Replacement Volume). The basis for charges against me is my current need for psychiatric treatment and my ongoing problems with abuse of prescribed medications and periodic alcohol abuse.

I have not practiced medicine in Maryland since November 1990. I hereby affirm that I do not have any hospital privileges in Maryland, Georgia, or any other state in the United States. I am licensed to practice medicine in the State of Georgia. I acknowledge upon acceptance of this letter, the board will send a copy of this letter of surrender to

Mr. Andrew Watry, Executive Director
Georgia Composite State Board of Medical Examiners
166 Pryor Street, S.W.
Atlanta, Georgia 30393

I agree to sign DEA Form 104, Voluntary Surrender of Controlled Substances Privileges. I acknowledge that the board will send my DEA Registration Certificate, DEA Form

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104, and a copy of this letter of surrender to Robert Bickel, Group Supervisor, DEA, 31 Hopkins Plaza, Room 955, Baltimore, Maryland 21201.

I hereby affirm that I do not have any DEA order forms for schedule I or II drugs.

I acknowledge that the board will send my Maryland CDS Registration Certificate and a copy of this letter of surrender to Charles Tregoe, Chief, Division of Drug Control, 4201 Patterson Avenue, Baltimore, Maryland 21215.

Before the board accepts this letter of surrender as a resolution of case number 87-0599, I must present to the board the following:

1. Maryland License D10875, Renewal Certificate and wallet-size renewal card.
2. United States Drug Enforcement Administration Registration Certificate AP6784933 which permits me to prescribe controlled dangerous substances in Maryland, and DEA Form 104.
3. Maryland Controlled Dangerous Substances Registration Certificate issued by the Maryland Division of Drug Control.
4. All prescription pads in my possession or control.
5. All controlled substances in my possession or control other than those that are prescribed to me by another licensed physician.

In executing this letter of surrender, I understand that I may apply for reinstatement of my license to practice medicine in Maryland at any time that I wish, provided that I have a letter from my treating psychiatrist which states that he or she believes that I am mentally competent to practice medicine.

If I apply for reinstatement of my license I acknowledge that I bear the burden of demonstrating to the board that I am competent to practice medicine. I understand that the board will require a statement from my treating psychiatrist which states that he or she believes I am competent to practice medicine. I further understand that the board will require an independent psychiatric evaluation of me prior to deciding whether to reinstate my license. I understand that the board will consider the independent psychiatric evaluation of me in deciding whether to reinstate my medical license.

Further, I understand that I must demonstrate that I have the cognitive and clinical competence to practice medicine. Additionally, I must demonstrate that I have taken fifty continuing education hours, which is appropriate for the field of medicine I wish to enter, for each year I have not practiced. I further understand that the board may require that I be appropriately evaluated for clinical competence prior to my reinstatement. I understand that I must demonstrate to the board's satisfaction that I possess good moral character as specified in *Md. Health Occ. Code Ann.* §14-307(b) (1991 Replacement Volume).

Until the board grants my request for reinstatement, I understand that I may not give medical advice to any in-

dividual,¹ for compensation or otherwise, and cannot prescribe medication. In other words, I understand that the surrender of my license means that I am an unlicensed physician.

Finally, I wish to make clear that I have consulted with an attorney before signing this letter SURRENDERING my license to practice medicine in Maryland. I understand both the nature of the matters against me and also this letter of surrender. I make this decision voluntarily and knowingly.

Sincerely,
THOMAS A. PITTMAN, M.D.

On behalf of the Board of Physician Quality Assurance, on this 17th day of July 1991, I accept Thomas A. Pittman, M.D.'s PUBLIC REVOCABLE surrender of his license to practice medicine in Maryland.

ISRAEL H. WEINER, M.D., Chairperson
Maryland Board of Physician Quality Assurance

■ ■ ■
In the matter of
Babu Y. Rao, M.D.
before the
Maryland Board of
Physician Quality Assurance

Order for reinstatement of a license

By final decision dated June 14, 1988, the Commission on Medical Discipline (CMD) revoked the medical license of Babu Y. Rao, M.D. (the respondent). The final decision provided as follows regarding respondent's petitioning for reinstatement of his license:

Respondent may move for reinstatement of his medical license by submitting evidence acceptable to the commission or its successor, the Maryland Board of Physician Quality Assurance, indicating that he is able to practice medicine in a competent fashion; and it is further

ORDERED, that any such motion for reinstatement must include proof that respondent has successfully completed an intensive, long-term physician retraining program such as that offered by the University of Maryland under the auspices of Edward J. Kowalewski, M.D., or in the alternative, has successfully completed a one-year residency program in the field of family practice.

Respondent petitioned the board through its settlement conference for reinstatement of his license on March 13, 1991. At its meeting on April 24, 1991, the board considered the settlement conference's recommendation and voted by an affirmative vote of the majority of the full authorized membership to enter into this consent order which supersedes the CMD's final order of June 1988.

1. This does not include dissemination of information such as teaching at a medical school.

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Findings of fact

1. The findings of fact of the CMD's final decision dated June 14, 1988, are incorporated by reference.
2. Respondent's license was revoked on June 14, 1988.
3. Respondent presented the following information at the settlement conference:
 - a. Respondent had attempted but was unable to find a year program in which to become retrained.
 - b. Respondent had taken the Special Purpose Examination (SPEX) and passed.
 - c. Respondent had been working in a preceptorship under the supervision of John S. Braxton, Jr., M.D. and Simon H. Carter, Jr., M.D., both of whom recommended that respondent be allowed to practice hands on medicine.
4. Respondent petitioned the board to stay the revocation of his license and permit him to practice medicine.

Conclusions of law

The board incorporates by reference the conclusions of law contained in the Commission on Medical Discipline's final decision of June 14, 1988.

Order

By a majority vote of the full authorized membership of the board considering this matter, it is hereby this 27th day of August 1991

ORDERED that the REVOCATION of respondent's license to practice medicine in Maryland is hereby STAYED; and be it further

ORDERED, that respondent is subject to the following conditions of PROBATION:

1. Respondent shall not prescribe any medication for which a state or federal permit is required;
2. Respondent may only practice medicine in the practice of John S. Braxton, Jr., M.D. and Simon H. Carter, Jr., M.D. and under their immediate supervision; and
3. Respondent must take twenty additional Category 1 hours of continuing education each year during the probation which is approved by the settlement conference or weekly review panel. Twenty hours must be taken by March 1, 1992; and be it further

ORDERED, that in the event that the respondent terminates his position with Drs. Braxton and/or Carter, he must notify the board within twenty-four hours of his termination; and be it further

ORDERED, that Drs. Braxton and Carter must submit monthly reports to the board, on October 1, 1991; November 1, 1991; December 1, 1991; January 1, 1992; and February 1, 1992, evaluating respondent's practice. The reports must include, at minimum, the number of hours respondent works, how many patients respondent sees weekly, the types of chief complaints presented to respondent, and an evaluation of respondent's treatment; and be it further

ORDERED, that Drs. Braxton and Carter must assure that respondent comply with the standards of medical recordkeeping enunciated by the board; and be it further

ORDERED, that by September 1, 1991, respondent must present evidence to the board, that he has presented copies of this order to Drs. Braxton and Carter; that Drs. Braxton and Carter understand their duties and responsibilities under the order and that they will comply with the requirements to supervise respondent and submit quarterly reports to the board as set forth above; and be it further

ORDERED, that respondent must continue to attend grand rounds at Johns Hopkins Hospital; and be it further

ORDERED, that on March 1, 1992, the Peer Review Management Committee (PRMC) of the Medical and Surgical Faculty (the Faculty) shall conduct a practice review and an office visit. PRMC will review at least thirty patient records, and will be permitted to review Drs. Carter's and Braxton's evaluations; and be it further

ORDERED, that after the board has received the PRMC's report, a settlement conference (the conference) will be scheduled to determine how to proceed, i.e. whether to lift all conditions of probation, whether to require respondent to conditioned practicing under supervision, or whether respondent must remediate any deficiencies noted by PRMC. At that time, respondent must submit a list of all continuing education courses completed from June 1, 1991 to March 1, 1992 and of his attendance at grand rounds; and be it further

ORDERED, that if the board receives a report that respondent has violated a term of probation, the board, WITHOUT PRIOR NOTICE AND AN OPPORTUNITY TO BE HEARD MAY LIFT THE STAY OF SUSPENSION OF RESPONDENT'S LICENSE, provided that respondent is given immediate notice of the charges and an opportunity to be heard thirty days after requesting same. Any findings made in such a hearing shall be by a preponderance of the evidence; and be it further

ORDERED, that this order is considered a public document pursuant to *Maryland State Government Code Ann.*, §§10-611, *et seq.*

ISRAEL H. WEINER, M.D., Chairperson
Maryland Board of Physician Quality Assurance

Consent

By signing this consent, I, Babu Y. Rao, M.D., hereby accept and agree to be bound by the foregoing consent order and its conditions and restrictions, consisting of seven pages.

1. By signing this consent, I hereby submit to this order and its conditions.
2. I acknowledge the validity of this order and the legal authority of the Board of Physician Quality Assurance to issue and enforce this order.
3. I acknowledge that by consent to this order, I am waiving

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my right to challenge in court the legal authority of the Board of Physician Quality Assurance to take action against my license to practice medicine in the state of Maryland.

I, Babu Y. Rao, M.D., have read this consent order and have had an opportunity to review same with attorney. I understand it and voluntarily agree to it.

I sign and consent to this order after having an opportunity to consult with counsel and with full understanding of the meaning and the terms of the order.

BABU Y. RAO, M.D. ■

■ ■ ■

**In the matter of
Bruce L. Regan, M.D.
before the
Maryland Board of
Physician Quality Assurance
Consent order**

On July 11, 1991, the State Board of Physician Quality Assurance (the board), pursuant to its authority under *Md. Health Occ. Code Ann.*, §14-404, charged Bruce L. Regan (the respondent) under the Maryland Medical Practice Act (the act), *Md. Health Occ. Code Ann.* §14-404 (1991 Replacement Volume).¹

The pertinent provision of the act under HO §14-404 provides

(a) Subject to the hearing provisions of §14-405 of this subtitle,

1. The basis of the allegations against respondent is conduct that occurred between August 1982 and February 1991. The applicable statute in effect in August 1982 was *Md. Health Occ. Code Ann.* §14-504(23) which provided

Subject to the hearing provisions of §14-505 of this subtitle, the board, on the affirmative vote of a majority of its full authorized membership, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:

Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State.

Chapter 593, Acts of 1957, effective July 1, 1987 inserted the following italicized words in former Section (23)

Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality *MEDICAL AND* surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this state.

Chapter 109, Section 1, Acts of 1988, effective July 1, 1988, designated the existing provisions of the section as subsection (a), and redesignated former Section (23) as Section (a)(22).

Section 11, Chapter 6, Acts 1990, approved February 16, 1990, effective on or about January 1, 1991, renumbered HO §14-504(a)(22) as HO §14-404(a)(22).

the board, on the affirmative vote of a majority of its full authorized membership, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee

(22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this state;

On September 11, 1991, a settlement conference (the conference) was held. Present were John F. Strahan, M.D., chief settlement officer; Frank A. Gunther, Jr., board member; J. Andrew Sumner, M.D., board member; Steven J. Poliakoff, acting board counsel; Elizabeth H. Trimble, assistant attorney general; Charles Cichon, case manager; Bruce L. Regan, M.D., respondent; and Barbara Mello, Esq., counsel for respondent. As a result of discussions at the conference, respondent agreed to enter into a consent order and the conferees recommended that the board accept a consent order as a resolution of this case. At the board meeting on September 25, 1991, by an affirmative vote of a majority of the board members who considered this case, the board voted to enter into the following consent order.

Findings of fact

1. At all times relevant to these charges, respondent was and is licensed to practice medicine in the state of Maryland.
2. Respondent maintains a private office for the practice of medicine at the Catonsville Professional Center, 405 Frederick Road, Baltimore, Maryland.
3. Respondent's practice is limited to psychiatry.
4. Patient A was a patient of respondent's from November 1980 to October 1990. Patient A initially sought treatment from respondent to determine if there was a psychological factor to the severe headaches he had been suffering for the past seven years. He continued in individual and group therapy with respondent for the next ten years.
5. Beginning in 1980, respondent prescribed for Patient A narcotic analgesics for his headache pain. He continued to prescribe this type of drug for Patient A in increasing dosages and increasing frequencies of use for the next ten years.
6. During the ten-year time period, respondent changed the analgesic drugs he prescribed for Patient A several times, but he made no notation in the patient records of his rationale for changing the medication.
7. In 1987, a neurologist with whom Patient A consulted, reported to respondent his concern of possible narcotic dependency, and the excessive number of drugs which the respondent was prescribing for this patient. Respondent did not alter his prescribing patterns in any way in response to this report.
8. In 1988, respondent was advised by Donald Pachuta, M.D. of the Medical and Chirurgical Faculty Committee

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on Drugs, that the psychiatrists on that committee were unanimous in concluding that the type of care and prescribing reflected in Patient A's records were "out of the purview of psychiatry and that a psychiatrist should never be the prescribing physician for [a narcotic analgesic] in a case like this, if ever ... The committee members believe you should treat him psychiatrically only." In spite of this warning, respondent continued to prescribe narcotic analgesics for Patient A for two and a half more years.

9. During his ten years of treatment of Patient A, the respondent failed to keep proper records reflecting the reasons for prescribing certain drugs to that patient, he prescribed drugs outside the area of his expertise, he prescribed parenteral narcotics in dosages in excess of those recommended, and he ignored indications that this patient was suffering physical effects of overmedication, including possible addiction. Further, he ignored direct warnings and instructions given him by the Medical and Chirurgical Faculty Committee on Drugs.
10. The board requested the Maryland Psychiatric Association to appoint a peer review committee to review the records on Patient A and to interview respondent about his treatment of this patient. This committee concluded, "that the care was inappropriate and the standard of care for chronic cephalgia on an outpatient basis by a psychiatrist clearly would preclude the use of a daily high frequency of injectable narcotics over an eight-year span."
11. One member of the peer review committee reviewed records on eight additional patients of respondent's for the purpose of considering his practice of prescribing and found those records to be "poorly organized and incomplete (records regarding medication were unclear, incomplete or inconsistent) and thus of little value to our wish to peruse the prescribing patterns for the respondent."
12. The peer review committee performed a practice review of respondent by examining the files of nine additional patients. With respect to one of these patients, the committee found a pattern of treatment similar to that of Patient A. As to the care of this patient, referred to in the committee's report as Case #9, they said

Case #9 reflects the very chaotic treatment of a profoundly disturbed and apparently borderline substance abuser. It is reminiscent of case #1 (Patient A) insofar as there is clearly a prescribing practice — in this case, of benzodiazepines — that is outside the accepted standard of care. In addition, there is notation in the medical record that there is a possibility of overmedication, yet the prescribing practice seems to continue without reflecting that concern.

... In addition to what appears to be inappropriate prescribing and recordkeeping of benzodiazepines in a patient quite likely to be abusing, there is also the prescription of many nonpsychiatric medications for the patient without any clear direction from an appropriate consultant or notations of physical examination and diagnosis.

13. Respondent's treatment of Patient A and Case #9 fell below the standard of care required of a physician in those

circumstances, and that deviation from the standard of care in each case continued for an extended period of time. Further, his recordkeeping regarding prescription drugs has been inadequate for a similarly lengthy period of time.

Conclusions of law

Based upon the foregoing findings of fact, the board concludes, as a matter of law, that the respondent is guilty of failing to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical care, in violation of *Md. Health Occ. Code Ann.* §14-404(a)(22).

Order

Based on the foregoing findings of fact and conclusions of law, it is this 22nd day of October 1991, by an affirmative vote of the majority of the full authorized membership of those members of the Board of Physician Quality Assurance of Maryland who considered this case, hereby

ORDERED, that respondent's license to practice medicine in the state of Maryland is suspended for a period of three years, beginning October 1, 1991; and it is further

ORDERED, that the suspension of respondent's license to practice medicine is IMMEDIATELY STAYED and respondent is placed on probation for a period of three years, beginning October 1, 1991, on the following terms and conditions:

1. On or before November 15, 1991, respondent shall submit to a psychiatric evaluation by a physician chosen from the following list:

Thomas Lynch, M.D.	Arthur Hildreth, M.D.
Lex Smith, M.D.	William Wimmer, M.D.
Irvin Cohen, M.D.	Robert Lessey, M.D.

This evaluation shall include psychological testing (including unconscious and characterological parameters) with a clear focus on whether characterological issues make respondent particularly vulnerable for this kind of difficulty (i.e., saying no to demanding patients, particularly in the area of prescribing drugs). Respondent shall be re-evaluated by that physician or another one approved by the peer review committee (the committee) on at least a yearly basis during the period of the probation. Respondent shall pay all costs associated with the evaluations. Respondent shall sign a release authorizing the physician who performs each evaluation to send copies of his reports to the board. Respondent shall sign a release authorizing the board to release the reports to the peer review committee and to the respondent's therapist.

2. Respondent shall participate in psychotherapy with Carl Schleifer, M.D. (therapist).
 - a. The therapist will see respondent for therapy on at least a weekly basis, and more often if the therapist thinks it is appropriate. If the therapist subsequently determines that therapy sessions do not need to take place on such a frequent basis, he shall notify the board of

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- the change in schedule. Respondent must follow the recommendations for the number of therapy sessions made to respondent.
- b. Respondent shall be responsible for all costs and expenses incurred in therapy.
 - c. Respondent shall continue in therapy for as long as this order is effective.
 - d. The therapist shall submit monthly reports to the committee, indicating that respondent is attending the therapy sessions as recommended.
 - e. In the event that respondent terminates therapy prior to discharge by the therapist, the therapist shall IMMEDIATELY notify the committee that respondent has terminated therapy.
 - f. In the event that Dr. Schleifer is unable to continue treatment, through no fault of respondent's, the therapist or the respondent must IMMEDIATELY notify the committee. The committee, within ten days of receipt of the notice, shall present respondent with a list of three approved psychiatrists from whom respondent must immediately select another therapist. The new therapist must inform the committee in writing that he/she agrees to perform all duties required under this order.
3. Respondent shall perform his private practice of psychiatry in Maryland only under the supervision of one of the following psychiatrists:
Richard H. Anderson, M.D.
Arthur M. Hildreth, M.D.
Mayer C. Liebman, M.D.
 4. Respondent shall meet with the supervising physician prior to November 1, 1991, and, following that meeting, the supervising physician shall notify the board, in writing, that he understands the terms of this order and has reviewed all previous peer review reports. The supervising physician will be furnished a copy of the results of the psychiatric evaluation set forth in paragraph 1 of this order as soon as it is completed.
 5. The supervising physician will meet with respondent for weekly supervisory sessions during the period of the probation, with the exception of the times when one or both are on vacation. He will determine how much time each week is needed to review respondent's practice. The supervision shall include clinical supervision of respondent's diagnosis and treatment of patients with particular emphasis on the rationale for and use of prescription medication. The supervising physician will also advise respondent on the setting-up and maintenance of patient record systems and will monitor his recordkeeping during the term of this order. Respondent will provide the supervising physician at each weekly meeting with a list of all the controlled dangerous substances which he has prescribed during the previous week.
 6. The supervising physician will make quarterly written reports about respondent's practice of psychiatry to the board, attention: Charles Cichon, case manager. The reports are due on January 1, April 1, July 1, and October 1 of each year of the probationary period, with the first report due on January 1, 1992.
 7. In the event that the supervising physician believes that respondent is in violation of this order, he shall IMMEDIATELY notify the board.
 8. In the quarterly report due July 1, 1993, the supervising physician will discuss whether weekly supervisory sessions should be continued. The board must ratify the supervising physician's recommendations before any change in supervision becomes effective.
 9. Respondent shall pay all costs associated with the weekly supervisory sessions and the quarterly reports. The supervising physician will submit a bill to respondent on a monthly basis. If respondent fails to pay the bill within thirty days, the supervising physician shall notify the board. Failure to pay all bills within thirty days shall result in a violation of this order.
 10. Respondent will be subject to an annual peer review of his practice by the peer review committee, administrative costs to be paid by respondent. The committee will submit a report to the board once each year on the results of the peer review of respondent's practice, the first report being due on or before October 1, 1992. Respondent must follow any recommendations made by the committee and endorsed by the board.
 11. Respondent shall practice in accordance with the law governing the practice of medicine in Maryland.
 12. Respondent shall be responsible for all costs for the supervision and psychiatric therapy that he is to obtain during this probation.
 13. Respondent shall, during the period of his probation, attend courses in one or more of the subject areas of prescribing controlled and dangerous substances, managing difficult and addiction-prone patients, psychopharmacology, and abusive and dangerous drugs, as directed by the supervising physician. Respondent shall pay all costs associated with his attendance at these courses.
- ORDERED, that if respondent violates any of the foregoing conditions of probation, the stay may be lifted and the board, after notification, a hearing, and a determination of violation, may impose any additional disciplinary sanctions it deems appropriate; and be it further
- ORDERED, that if respondent presents a danger to the public health, safety, or welfare, the board, WITHOUT PRIOR NOTICE AND AN OPPORTUNITY FOR A HEARING, MAY VACATE THE STAY OF SUSPENSION AND REIN-

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STATE THE SUSPENSION, provided that respondent is given notice of the board's action and an opportunity for a hearing within thirty days after respondent requests a hearing; and be it further

ORDERED, that, three years after the effective date of the order, that being the date on which the board signs the order, respondent may petition the board for termination of probation and reinstatement of his license without any conditions or restrictions. Prior to submitting his petition for reinstatement, respondent must be evaluated by a psychiatrist selected by the board. Respondent shall bear the burden of proving, to the board's satisfaction, that he has complied with all the conditions of this order. NOTHING IN THIS ORDER SHALL BE CONSTRUED AS A PROMISE BY THE BOARD TO REINSTATE RESPONDENT'S LICENSE WITHOUT CONDITIONS; and be it further

ORDERED, the respondent will be responsible for all costs incurred under this consent order; and be it further

ORDERED, that this consent order is considered a public document pursuant to *Md. State Gov't. Code Ann.* §10-611 *et seq.* (1984).

ISRAEL H. WEINER, M.D., Chairperson
Maryland Board of Physician Quality Assurance

Consent

By signing this consent, I hereby accept and agree to be bound by the foregoing consent order and its conditions and restrictions, consisting of twelve pages.

1. I admit to the truth of the findings of fact and agree with the conclusions of law set forth above.
2. I acknowledge the validity of this order as if made after a hearing in which I would have had the right to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by law.
3. I also recognize that I am waiving my right to appeal any adverse ruling of the board that might have followed any such hearing. By this consent I waive all such rights.
4. I understand that if I fail to comply with any of the conditions of probation enumerated above, the board, after notification, a hearing, and a determination of violation, may impose any additional disciplinary sanctions it deems appropriate.
5. I have had an opportunity to review this order. I voluntarily sign this order understanding its meaning and effect.

BRUCE L. REGAN, M.D.

BARBARA MELLO, ESQ., Counsel for Dr. Regan ■



In the matter of Sang Kyun Shin, M.D. before the Maryland Board of Physician Quality Assurance Final decision

On November 21, 1988, the Maryland Board of Physician Quality Assurance (the board) charged Sang Kyun Shin, M.D. (respondent), pursuant to §14-504, Health Occupations Article of the *Annotated Code of Maryland* (HO). Respondent was charged as follows:

Is convicted of or pleads guilty or *nolo contendere* with respect to a crime involving moral turpitude, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside; HO §14-504(6)

Is ... convicted ... by a court of any state or country for an act that would be grounds for disciplinary action under this section [HO §14-504(22)];

Grounds for disciplinary action under this section are

Is guilty of immoral or unprofessional conduct in the practice of medicine [HO §14-504(3)]

Willfully makes or files a false report or record in the practice of medicine [HO §14-504(12)];

A hearing was scheduled before a hearing officer pursuant to HO §14-504, commenced on July 7, 1989, and was continued on August 15, 1989. Present at the hearing were the hearing officer; Alice D. Ike, assistant attorney general, administrative prosecutor for the board; Anton J.S. Keating, Esquire, attorney for the respondent; respondent; respondent's witnesses and the court stenographer.

Summary of evidence

State exhibit 1. Letter to Dr. Shin dated November 21, 1988, four pages.

State exhibit 2. Charges issued November 21, 1988, four pages.

State exhibit 3. Summons and notice of charges and hearing, two pages.

State exhibit 4. Certified copy of docket entries, two pages.

State exhibit 5. Criminal information number 28736403, three pages.

State exhibit 6. Statement of facts, 11 pages.

Respondent introduced the following exhibits which were admitted into evidence, in part over objection by the administrative prosecutor:

Respondent exhibit 1. Curriculum vitae of respondent.

Respondent exhibit 2. Letter of Louis C. Breschi, M.D.

Respondent exhibit 3. Letter of Jane T. Lew, M.D.

Respondent exhibit 4. Letter of Betty Jane Ristau.

Respondent exhibit 5. Letter of Kathryn Ayers.

Respondent exhibit 6. Letter of Chang Ho Kim.

Respondent exhibit 7. Letter of Chi Bon Jang, D. Min.

Respondent exhibit 8. Letter of David M. Lanphear, M.D.

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- Respondent exhibit 9.* Letter of Davood Badie, M.D.
Respondent exhibit 10. Letter of Lawrence K. Moran.
Respondent exhibit 11. Letter of Nancy M. Thorpe.
Respondent exhibit 12. Letter of Paula Ann Sexton.
Respondent exhibit 13. Letter of Jean M. Mikanowicz.
Respondent exhibit 14. Letter of Margaret L. Stickler.
Respondent exhibit 15. Letter of Kathleen A. Thomas.
Respondent exhibit 16. Letter of Karen R. Beale.
Respondent exhibit 17. Letter of Carl E. Henderson.
Respondent exhibit 18. Letter of Edward J. Kennedy III.
Respondent exhibit 19. Letter of Young C. Shin, M.D.
Respondent exhibit 20. Certificate of appreciation.
Respondent exhibit 21. Franklin Square Hospital — Contributions.
Respondent exhibit 22. Other charitable contributions.
Respondent exhibit 23. Korean American citizen plaque.
Respondent exhibit 24. Letter from Dr. Kim.
Respondent exhibit 25A. List of patients billed for not keeping appointments.
Respondent exhibit 26A. List of patients billed where not keeping appointments.
Respondent exhibit 27. Subpoena duces tecum for private paying patients and list.
Respondent exhibit 28A. List of private patients — Essex office (throat cultures given in same situation).
Respondent exhibit 29A. List of private patients — Fallston office.
Respondent exhibit 30. Summary
Respondent exhibit 31A. Judgment calls.
Respondent exhibit 31B. Acute rheumatic fever in western Pennsylvania and the tristate area.
Respondent exhibit 31C. Preventive value of diagnosing and treating streptococcal throat infections.
Respondent exhibit 31D. The recognition of streptococcal pharyngitis.
Respondent exhibit 31E. Streptococci in children's respiratory infections, diagnosis, and treatment.
Respondent exhibit 31F. Report of the Committee on Infectious Diseases, twenty-first edition, 1988.
Respondent exhibit 31G. Severe group A streptococcal infections with a toxic shock-like syndrome and scarlet fever toxin A.
Respondent exhibit 32. Letter of Margaret Anzalone dated August 10, 1989 with list of physicians prosecuted by the Medicaid Fraud Control Unit and three final orders; Letter of Judith Griffith dated August 11, 1989 with two final orders.
Respondent exhibit 33. List of physicians prosecuted by the Medicaid Fraud Control Unit, and letter of Gale Caplan dated June 26, 1989.

The following documents were introduced into evidence without objection as hearing officer's exhibits:

Hearing officer exhibit 1. Stipulation signed by Alice D. Ike, Esquire and Anton J.S. Keating, Esquire, six pages.

Hearing Officer Exhibit 2. List of witnesses.

The following persons testified for the respondent:

Davood Badie, M.D., a pediatrician practicing in Fallston.
Patricia Lewis, whose children were seen for nine years.
Patricia Day, a physical therapist's aide who has known the respondent seven and one-half years and has used him as her family pediatrician.

Young Ho Yu, M.D., an obstetrician/gynecologist who refers patients to the respondent for pediatric care and who has known the respondent since 1954.

Young C. Shin, M.D. (no relative), an otolaryngologist who practices in Havre de Grace.

T. Edgie Russell, M.D., an obstetrician/gynecologist since 1946.

Kathy Stewart, R.N., whose children have seen respondent for seventeen years.

Peggy Orlick, R.N., whose children see respondent.

Kathy Thomas, a kindergarten aide who has used the respondent's pediatric services since 1977.

Joann Santos, M.D., a pediatrician who regularly refers her patients to the respondent.

On September 20, 1989, the hearing officer submitted the proposed findings of fact, conclusions of law, and recommendations (recommended decision) to the respondent and the state. Pursuant to State Government Article, §10-212, the parties were advised of their right to file exceptions and make oral argument on exceptions to the board. By letter dated November 6, 1989, the board notified the parties that it had received no exceptions and that the board would consider the recommended decision at its November 22, 1989 meeting. The board reviewed the recommended decision on November 22, 1989. The board postponed consideration of the recommended decision until Wednesday, December 13, 1989. At that meeting, on an affirmative vote of a majority of its full authorized membership, the board decided as follows and issues this sixteen page final order and decision.

Findings of fact as to the charges

The board finds based on the testimony and exhibits introduced at the hearing, by clear and convincing evidence, that

1. At all times relevant, respondent was licensed to practice medicine in Maryland and was practicing as a pediatrician.
2. The respondent pled guilty to Medicaid fraud in violation of Article 27, §230C pursuant to criminal information #28736403 in *State of Maryland v Sang Kyun Shin*, on December 30, 1987. On that date, the court's verdict was guilty on count 1 of the criminal information (State exhibits 1 through 6).
3. On December 30, 1987, respondent was placed on two

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years of supervised probation under Article 27, §641, received a fine of \$10,000, and was ordered to pay restitution in the amount of \$8,272.50 to the Department of Health and Mental Hygiene.

4. The time for filing an appeal to set aside respondent's guilty plea and conviction has passed.
5. Respondent admitted to acts sufficient to support the plea accepted by the criminal court.
6. The respondent was audited on his Medicaid billings by representatives of the Medicaid Fraud Unit. Twenty bills were found where the respondent had not seen the patient on the particular occasion for which he had been billed.
7. Medicaid fraud is a crime of moral turpitude that involves willfully submitting false reports in the practice of medicine.

Conclusions of law

By clear and convincing evidence, the board concludes as a matter of law that respondent committed the following act:

... pleads guilty ... to a crime involving moral turpitude, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside; §14-504(6)¹

By clear and convincing evidence the board concludes as a matter of law that respondent did not commit the following acts:

Is ... convicted ... by a court of any state or country for an act that would be grounds for disciplinary action under this section [HO §14-504(22)];

Is guilty of immoral or unprofessional conduct in the practice of medicine [HO §14-504(3)];

Willfully makes or files a false report or record in the practice of medicine [HO §14-504(12)].²

Facts as to the sanction

1. The respondent testified that he arrived in his present circumstances because, when he was audited and the twenty cases were called to his attention, he sought the advice of counsel. Counsel informed him that he might either make a plea bargain with the state or he might

contest the case. If he contested the case, the fee would be in the range of \$50,000 to \$60,000. If he plea bargained, however, the criminal offense on his record would do him no harm and the Commission on Medical Discipline, which was the predecessor to the present board, could be accurately predicted to take no action against his license since it never took action against anyone's license in Medicaid fraud cases, even where the fraud was in excess of a half million dollars. The respondent accepted the advice of his counsel and entered into a plea bargain without contesting the state's factual allegations whereupon the law promptly changed, a new board was established, and a new, much firmer policy was instituted with regard to Medicaid fraud. The respondent's discussion of his legal tactical situation is believable, but does not either alter the fact that he had pled guilty to Medicaid fraud.

2. Respondent admitted that he did send requests for Medicaid payment on twenty occasions spread over three years when the patients were repeated "no shows." The total submittal over three years amounts to \$335. Respondent did not fake treatment notes for these occasions, but annotated the histories to show that the patients did not keep their appointments.
3. The respondent has a reputation for being a dedicated, hard working, very competent pediatrician. The respondent was portrayed by the witnesses previously identified as being totally dedicated and extremely capable in his practice. He immerses himself in his practice and his family and little else. He is available at all times to his patients. If the telephone rings at a medical conference, it is a standing joke that the call is probably for the respondent. The respondent was praised in the strongest terms by persons ranging from the stature of Dr. Russell through various kinds of health care professionals and lay witnesses. All perceived him as being uncompromisingly honest, hard working, careful, and caring. None saw him as having any potential for committing a deliberate fraud. Dr. Russell recommended him for his present practice and remains firmly supportive. Other pediatricians and health care providers entrust their children to the respondent. All witnesses were impressive. All spoke with conviction and believed in their testimony.
4. The respondent testified on his own behalf and was also believable. Dr. Shin makes well over \$100,000 per year and has no need to defraud the government of \$335 spread over a three-year period. The facts support his version, that in frustration with persons who were multiple no shows he sent off these requests for payment, feeling that somehow he and his people should be at least compensated for staying the extra hours to try to help people who then did not show and did not have the courtesy to call. Regardless, a case of fraud has been made out; the respondent's conduct amounts to a serious lapse in judg-

1. In reaching this decision, the board notes that respondent's counsel contended that the criminal court, by its issuance of probation before judgment overturned respondent's plea of guilty so that there is no such plea now in existence and the board, therefore, does not have jurisdiction to sanction respondent under §14-504(6) which provides, in pertinent part, "is convicted of or pleads guilty or *nolo contendere* with respect to a crime involving moral turpitude" The board adopts the hearing officer's conclusion as set forth in the addendum.

2. Respondent was given probation prior to judgment under Article 27, §641. Probation prior to judgment is not a conviction. *Myers v State*, 303 Md. 639, 496 A.2d 312 (1988). Consequently this charge and the underlying grounds must be dismissed. (1985); *State v. Shilling*, 75 Md. App. 233, 540 A.2d 1184

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ment resulting in his plea of guilty and the imposition of probation before judgment.

5. The respondent has made restitution to the Department of Health and Mental Hygiene in the amount in excess of \$8,272.50 as directed by the criminal court, has paid the court costs assessed in the amount of \$95, and has further paid the fine assessed of \$10,000, for a total payment of \$18,367.50.

Order

By a majority of the full authorized membership of the board considering this case, it is this 16th day of January 1990 hereby

ORDERED, that respondent's license is SUSPENDED; and it is further

ORDERED, that said suspension is IMMEDIATELY STAYED pending respondent's compliance with the following condition: That respondent will indicate in all medical records the reasons for ordering a throat culture; and be it further

ORDERED, that on or about June 1, 1991, respondent will submit to a peer review of his practice to determine if he has met the condition of probation; and be it further

ORDERED, that on or about January 16, 1992, respondent may petition the board to lift the suspension on his license; and be it further

ORDERED, that the following charge and underlying grounds

Is ... convicted ... by a court of any state or country for an act that would be grounds for disciplinary action under this section [HO §14-504(22)];

Grounds for disciplinary action under this section are

Is guilty of immoral or unprofessional conduct in the practice of medicine [HO §14-504(3)];

Willfully makes or files a false report or record in the practice of medicine [HO §14-504(12)];

are DISMISSED; and be it further

ORDERED, that this is a final order and as such is considered a public document pursuant to State Government Article of the *Annotated Code of Maryland*, §§10-611 *et seq.*

ISRAEL H. WEINER, M.D., Chairperson
Maryland Board of Physician Quality Assurance

Notice of appeal

Pursuant to §14-508(b), Health Occupations article, *Annotated Code of Maryland*, any person aggrieved by a final decision of the board under HO §14-504 of this subtitle, may not appeal to the secretary or to the board of review, but may take a direct judicial appeal. The appeal shall be provided for judicial review of final decisions in the Administrative Procedure Act and Maryland B Rules of Procedure.

ISRAEL H. WEINER, M.D., Chairperson
Maryland Board of Physician Quality Assurance

Addendum

I. Jurisdictional argument

The judge in the respondent's criminal case did not overturn his plea of guilty by entering probation before judgment, and, therefore, the board has jurisdiction to act against the respondent and his license.

The respondent pled guilty to Medicaid fraud in violation of *Maryland Annotated Code*, Article 27, §230C (1987 replacement volume), in the circuit court for Baltimore City. The judge imposed probation before judgment pursuant to *Maryland Annotated Code*, Article 27, §641 (1987 replacement volume). If the judge's action had had the affect of overturning the plea, the board would actually have no jurisdiction in the present case. This is because jurisdiction in the present case is predicated upon the existence of a plea of guilty as contemplated by the Health Occupations Article, §14-504(6), which authorizes the board to take disciplinary action if a licensee

Is convicted of or pleads guilty to or *nolo contendere* with respect to a crime involving moral turpitude, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside.

It is undisputed that the respondent pled guilty to a crime, so the remaining question is whether the plea remained in existence after the judge took his action. The judge acted pursuant to *Maryland Annotated Code*, Article 27, §641 (1987 replacement volume), which provides in pertinent part:

(a)(1)(i) Whenever a person accused of a crime pleads guilty or *nolo contendere* or is found guilty of an offense, a court exercising criminal jurisdiction, if satisfied that the best interests of the person and the welfare of the people of the state would be served thereby, and with the written consent of the person after determination of guilt or acceptance of a *nolo contendere* plea, may stay the entering of judgment, defer further proceedings, and place the person on probation subject to reasonable terms and conditions as appropriate

It is clear that the judge granted probation before judgment as an act of judicial mercy. He was empowered to do this by the existence of a plea of guilty on the part of the respondent. Without the plea of guilty, he would have had no authority to enter probation before judgment, and would have had to try the case to a conclusion.

It is clear that the plea of guilty continues to exist in the criminal court since §641(b) also provides

Upon violation of a term or condition of probation, the court may enter judgment and proceed with disposition of the person as if the person had not been placed on probation.

If the court is empowered to enter judgment upon violation of a term or condition of probation, it must do so based upon a pre-existing plea of guilty as in the present case. If it were not so, the court would have no basis for entry of the guilty verdict and judgment in the event of a violation of the terms of probation.

Board of Physician Quality Assurance Actions

II. Statutory authority

Maryland Health Occupations Code Annotated, §14-504.

Denials, reprimands, probations, suspension, and revocations
— Grounds.

- (a) Subject to the hearing provisions of §14-505 of this subtitle, the board, on the affirmative vote of a majority of its full authorized membership, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee
 - (3) Is guilty of immoral or unprofessional conduct in the practice of medicine;
 - (11) Willfully makes or file a false report or record in the practice of medicine.

Maryland Health Occupation Code Annotated, §14-505. —
Hearings.

- (a) Except as otherwise provided in the administrative Procedure Act, before the board takes any action under §14-504 of this subtitle or §14-303, §303.1, or §14-303.2 of this title, it shall give the individual against whom the action is contemplated an opportunity for a hearing before a hearing officer.
- (b) The hearing officer shall give notice and hold the hearing in accordance with the Administrative Procedure Act except that factual findings shall be supported by clear and convincing evidence.
- (c) The individual may be represented at the hearing by counsel.
- (e) After performing any necessary hearing under this section, the hearing officer shall refer proposed factual findings to the board for the board's disposition. ■



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3. *Gastroesophageal reflux disease (GERD)*—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

Contraindication: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H₂-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H₂-receptor antagonists.

Precautions: General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

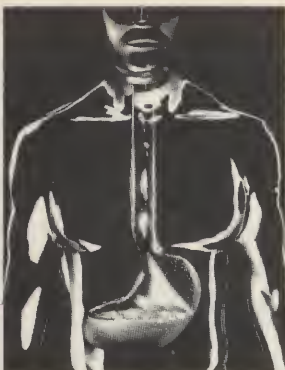
Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method. PV 2093 AMP [101591]

Additional information available to the profession on request.

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A Clinical Moment With...Diabetes

When are sulfonylurea drugs worth a trial?

Doctor, I am a 55-year-old woman and have had diabetes for ten years. I weigh 170 lbs and for my height of 61 inches, my weight should be between 110 and 120 lbs. Since the onset of my diabetes, I have seen several physicians and they all treat me the same. First I am given one sulfonylurea drug. After a few months, another is prescribed. This continues for about one year. Finally, the doctor wants to start insulin, saying the oral agents are ineffective in my situation. That is when I change to another physician and go through the same routine. My weight stays the same. The doctors have given me meal plans to follow but I do not understand them. My husband fusses with me to do something about the diabetes before I get foot complications and lose a leg as my mother did. Isn't there one sulfonylurea drug that is potent enough to control my diabetes without my having to use insulin? Is there a simple meal plan that I can understand?

The most important steps to take with patients with this type of problem are to take time to sit down and talk, take a good diet history and a good social history, and construct a meal plan that they understand and can live with. In addition, a good diabetes education program, including further diet instruction and the reading and understanding of package labeling, is essential. Patients need to know why the sulfonylurea drugs were used and why they probably failed, as well as why insulin was recommended and why it should be accepted as the best form of therapy when the blood glucose cannot be controlled by meal plan and sulfonylurea therapy. If patients attend a good diabetes education program, there will be no need to change physicians every time the use of insulin is suggested. If the spouse appears to be appreciative of a patient's needs, the spouse should be included in the education program.

In fairness to the physicians who treated this woman, there are some patients who have no desire to participate in a diabetes education program; no progress can be made if help is not accepted. Sometimes, however, when a patient history is taken or previous meal plans are reviewed, not enough effort is put forth by physicians and their staffs. Sulfonylurea drugs are indicated in noninsulin-dependent diabetic patients who cannot be managed by diet alone. However, a diet acceptable to the patient should be tried with all overweight, nonketotic, diabetic patients for at least three months before

the use of a sulfonylurea drug is suggested. The sulfonylurea drug should be used in addition to the diet and not instead of it.

Which sulfonylurea drug should be used depends on the physician and the patient. Tolbutamide is the least potent; tolazamide, glipizide, and glyburide are somewhat more potent; and chlorpropamide is the most potent, based on Food and Drug Administration dosage schedules. All these drugs have remarkably few side effects. The possibility of a disulfiram effect should be called to the attention of the patient. This effect can be used beneficially in those patients who consume too much alcohol. The other effect noted in patients who eat irregularly or who use excessive amounts of alcohol is hypoglycemia; changing the patient's habits or dose reduction is the needed treatment. Hyponatremia, often mentioned as a complication of chlorpropamide therapy, is rare and, when seen, is almost always related to concomitant diuretic or other drug therapy. Patients using sulfonylurea drugs should be seen in the office every two to three months depending on the degree of control achieved. Physicians should become very familiar with one of the sulfonylurea drugs and use it almost exclusively. Changing from one to another is usually not worthwhile.

If diet and sulfonylurea therapy fail to control the hyperglycemia, insulin therapy is essential. If the reasons for the change in therapy are understood, the change will be accepted in the vast majority of patients.

Primary failure of a sulfonylurea drug occurs in situations in which a noninsulin-dependent patient does not show a blood glucose drop with a maximum acceptable dose of the drug after one month of treatment. Primary failure occurs in about 20 percent of patients and the cause is unknown.

Secondary failure of sulfonylurea drugs occurs in patients who respond to therapy for two or more months and then do not respond. In a large series of patients, secondary failure will occur at a rate of about 2 percent per month. The author has followed several patients successfully on sulfonylurea therapy for over fifteen years.

The University Group Diabetes Program of twenty years ago showed that diet and exercise therapy were inadequately used in the management of most noninsulin-dependent diabetic patients.

DEWITT E. DELAWTER, M.D.
Editor



A MEDICAL TEST SHOULD **NOT** SCARE PEOPLE HALF TO DEATH!



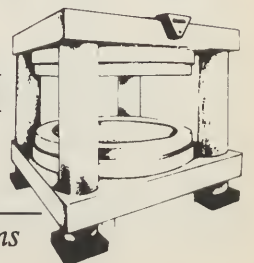
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- HIV counseling supervisory skills**, sponsored by the Maryland AIDS Professional Education Center, in Annapolis, MD. Info: Sylvia Scherr, 410-328-8639. **May 4-5**
- Pediatric HIV clinical preceptorships**, sponsored by the Maryland AIDS Professional Education Center, in Baltimore, MD. Info: Sylvia Scherr, 410-328-8639. **May 5**
- Subspecialty care in general pediatric practice**, at the University Club, UMAB campus, Baltimore, MD. 1 Cat 1 AMA/PRA credit. Fee: \$50. Info: Richard Ringel, M.D., 410-328-6666. **May 5**
- 12th annual Abraham H. Finkelstein memorial lecture**. Info: Bonnie Winters, 410-328-6777. **May 8**
- HIV: New frontiers for mental health—The triple diagnosed client**, sponsored by the Maryland AIDS Professional Education Center, in Columbia, MD. Info: Sylvia Scherr, 410-328-8639. **May 15**
- Advanced laparoscopic general surgery**, in Towson. 16 Cat 1 AMA/PRA credits. Fee: \$3,300. Info: Pat Rahmiow, 410-321-5481. **May 15-16**
- HIV coordinator skills course**, sponsored by the Maryland AIDS Professional Education Center, in Hagerstown, MD. Info: Sylvia Scherr, 410-328-8639. **May 21-22**
- AIDS, women and reproduction: Medical, legal and ethical challenges**, sponsored by the Maryland AIDS Professional Education Center, in Baltimore, MD. Info: Sylvia Scherr, 410-328-8639. **June 11**
- 18th annual family medicine review course**, in Ocean City, MD. 26.5 Cat 1 AMA/PRA credits. Fee: \$395. Info: Sharon Stenhouse, 410-328-3956. **June 21-26**
- 11th annual update in obstetrics and gynecology**, in Annapolis, MD. Info: Sharon Stenhouse, 410-328-3956. **June 25-26**

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The annual meeting of the Virginia Society of Otolaryngology—Head and Neck Surgery , at the Boar's Head Inn, Charlottesville, VA. Info: Donna Scott, 804-353-2721.	May 1–2
Trauma is no accident: 92/societal violence—A national epidemic , sponsored by the American Trauma Society, at the McLean Hilton, McLean, VA. Info: 800-556-7890.	May 6–8
Rural health: Caring for the country , sponsored by the National Rural Health Association, at the Hyatt Regency Crystal City Hotel, Washington, DC. Info: Robert Quick, 816-756-3140.	May –9
Practice patterns, outcomes, and the quality of life , sponsored by the Baltimore City Medical Society, at the Johns Hopkins Hospital. 1 Cat 1 AMA/PRA credit; 1 AAFP prescribed hour. Info: Lorraine Wallace, 410-625-0022.	May 7
Clinical auscultation of the heart , sponsored by the American College of Cardiology, at the Georgetown University Medical Center, Washington, DC. 18 Cat 1 AMA/PRA credits. Info: Registration secretary, 800-257-4739.	May 13–15
44th annual meeting and scientific session of the Maryland Academy of Family Physicians , at the Sheraton Ocean City Resort and Conference Center, Ocean City, MD. 30.75 Cat 1 AMA/PRA credits; 30.75 AAFP prescribed hours. Fee: \$195 MAFP members; \$225 nonmembers; \$110 paramedics; free for residents, medical students, and MAFP retired and life members. Info: Francis C. Bruno, M.D., 410-747-1980.	May 13–17
Virginia Society of Ophthalmology annual meeting , at the Marriott, Richmond, VA. Info: Donna Scott, 804-353-2721.	May 15–16
Revitalization for emergency professionals and spouses , sponsored by the Maryland Chapter, American College of Emergency Physicians, at the Morrison House Hotel, Alexandria, VA. Fee: \$175 physicians; \$25 spouses with physician. Info: 410-727-2237.	May 16
Evolution of critical care to the year 2000 , sponsored by the Baltimore City Medical Society, at Church Hospital, Baltimore, MD. 1 Cat 1 AMA/PRA credit; 1 AAFP prescribed hour. Info: Lorraine Wallace, 410-625-0022.	June 4
A focused seminar on peripheral pain , sponsored by the Washington Adventist Hospital, at the Hyatt Regency Bethesda, Bethesda, MD. Info: Robert Gerwin, M.D., 301-982-7944.	July 17–19

Shady Grove Adventist Hospital

9901 Medical Center Drive, Rockville, MD. Info: 301-279-6115.

Estrogen replacement.	May 7
Sleep disorders: Neurological perspective.	May 14
Fundus exam and systemic disease.	May 21
The challenge of chronic lymphedema.	May 28
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Noninvasive assessment of coronary artery disease.	June 18
Dangerous marine organisms.	June 25
Pain control in the cancer patient.	July 2
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Rheumatology.	July 16
Depression: Treatment in the office setting and comparison of newer and older agents.	July 23
Current concepts in plastic surgery.	July 30

The Johns Hopkins Medical Institutions

All courses at the Turner Auditorium unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Education, 720 Rutland Ave., Baltimore, MD 21205 (410-955-2959).

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| Pediatric allergy and immunology for the practitioner. Cat 1 AMA/PRA credit available. | May 7-8 |
| The Philip A. Tumulty topics in clinical medicine 1992. 38 Cat 1 AMA/PRA credits. Fee: \$650 physicians; \$400 residents and allied health professionals. | May 11-15 |
| The 5th summer institute in environmental health studies. Info: Dr. Jacqueline Corn or Catherine Walsh, 410-955-2609. | May 18-29 |
| Symposium on the prevention of developmental disabilities in infants and toddlers. 14 Cat 1 AMA/PRA credits. Fee: \$200 physicians; \$100 residents, fellows, and allied health professionals. | June 4-5 |
| Control of biohazards in the research laboratory. Info: Dr. Jacqueline Corn, 410-955-2609. | July 13-17 |

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- Visiting preceptorship in pediatric critical care medicine.** Ongoing five-day preceptorship by appointment. 40 Cat 1 AMA/PRA credits. Fee: \$600.
- Ophthalmic electrophysiology technician training course.** Ongoing one-week course by appointment. The Wilmer Eye Institute, Baltimore, MD.
- Ophthalmology grand rounds.** Audiovisual continuing education series of case discussions for clinicians; 3-8 topics per conference. Thursdays, 7:30-9:00 a.m. 2 Cat 1 AMA/PRA credits per session. Info: 410-955-5700.
- Neuro-ophthalmology conference.** Held twice per month. Info: 410-955-5700.
- Cornea conference.** Held monthly. Info: 410-955-5700.
- The department of radiology and radiological sciences** offers several courses in abdominal and obstetrical ultrasound. Info: P. Williams, 410-955-3169.
- Visiting physicians.** Offered throughout the year for experience in the lab and participation in read-in sessions; by appointment only. 40 Cat 1 AMA/PRA credits. Fee: \$500.
- Johns Hopkins medical grand rounds.** Accredited audiovisual continuing education series of case discussions for clinicians; thirty topics per year in five bimonthly programs. Individual and group subscriptions. 40 Cat 1 AMA/PRA credits. Info: 410-955-3988.
- Microsurgery training at the Johns Hopkins Hospital.** One-week program offered continuously throughout the year. 40 Cat 1 AMA/PRA credits. Info: P. Williams, 410-955-3169.

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The Medical and Chirurgical Faculty of Maryland maintains a Placement Service for the convenience of Maryland physicians, hospitals, and communities in search of candidates for positions available in our state. A detailed description of such opportunities should be forwarded to:

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Physicians wishing to locate in Maryland are invited to submit a resume to be kept on file with the *Physician Placement Service*. Candidates are requested to inform the Faculty when they are no longer available for consideration for opportunities in Maryland.

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Manuscripts may be sent to Editor, *MMJ*, 1211 Cathedral St., Baltimore, MD 21201-5585. Articles are accepted for publication on the condition that they are contributed solely to this journal. Transmittal letters should designate one author as correspondent and include his/her address and telephone number. Manuscripts are reviewed by editorial board members and guest reviewers.

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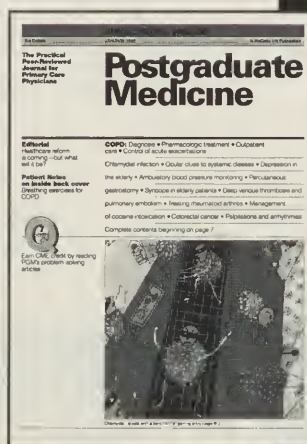
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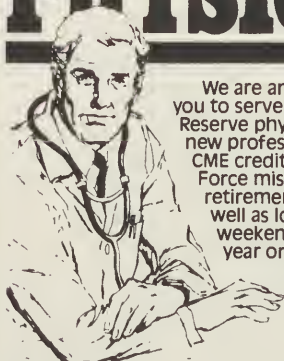
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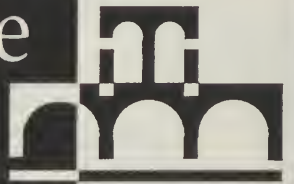
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BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully

monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecostasia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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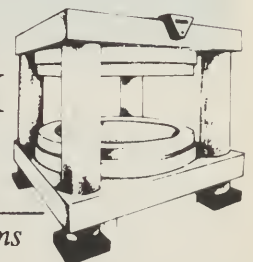
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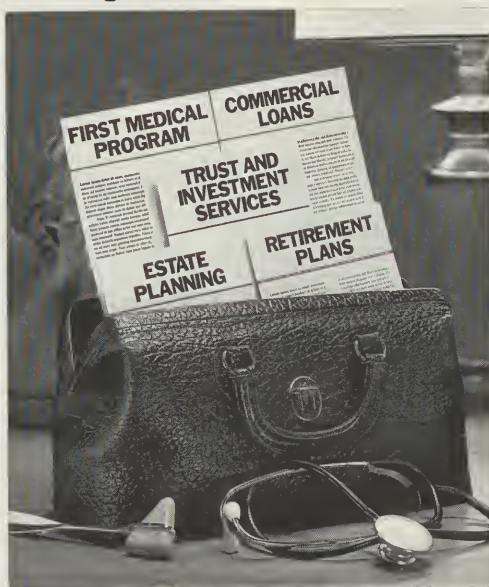
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Dr. Dennis, dean emeritus of the University of Maryland School of Medicine, stands before an architectural model of the new VA Medical Center, an endeavor planned during his tenure, while behind him the structure takes shape.

Cover photo and design by Virginia Carter

Maryland's newest physical rehab center already has 20 years experience.



Baltimore is a city known internationally for its outstanding medical care. Now the tradition continues with the addition of the new Maryland General-Bryn Mawr Rehab Center at Maryland General Hospital. This specialty center for physical medicine and rehabilitation offers Bryn Mawr Rehab's 20 years of experience and leadership in the field of rehabilitation medicine.

The partnership between Maryland General Hospital and Bryn Mawr Rehab is truly unique. For the first time in Maryland, two high quality institutions with long histories of health care achievement are coming together to make a major commitment to rehabilitation medicine.

The Maryland General-Bryn Mawr Rehab Center, the region's most modern and conveniently located rehabilitation facility, provides a continuum of care in physical and cognitive rehabilitation services

including brain injury, stroke, orthopedics, arthritis, amputee services and multiple sclerosis, among others.

Most importantly, everyone on the Maryland General-Bryn Mawr Rehab team is personally and professionally dedicated to helping patients reach their highest level of independence. Our guiding philosophy is team-centered care, focused upon the individual needs of our patients and their families. This is what makes Maryland General-Bryn Mawr Rehab Center a very special place for rehabilitation care.

To learn more about Maryland General-Bryn Mawr Rehab Center or to arrange a tour, please call Mary Filippelli our administrative director at (301) 225-8380.

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Executive Director's Newsletter

June 1992

New Med Chi Officers Elected

On May 2, 1992, the Med Chi House of Delegates elected *Joseph Snyder, M.D.* of Silver Spring to the office of president-elect. Dr. Snyder is an ophthalmologist and a member of the Montgomery County Medical Society.

Also during the meeting, *Albert L. Blumberg, M.D.* of Baltimore was elected to the office of treasurer for 1992. Dr. Blumberg specializes in therapeutic radiology and is a member of the Baltimore County Medical Society.

Henry N. Wagner, M.D. and *Roland Smoot, M.D.* were re-elected as delegates to the American Medical Association (AMA). Resident member *Eric Lon Shampaine, M.D.* and student member *Robert Ferris* were elected as alternate delegates to the AMA.

The Med Chi House of Delegates also elected the following physicians to the positions listed below:

Finney Fund Committee—*Susan R. Guarnieri, M.D.*, Baltimore City (5-year term 1993-1998)

Board of Physician Quality Assurance*—*Augusto R. DeLeon, M.D.*; *Hilary T. O'Herlihy, M.D.*, Anne Arundel County; *Mary Newman, M.D.*, Baltimore City; *Sidney B. Seidman, M.D.*, Baltimore County; *Cheryl E. Winchell, M.D.*, Montgomery County; *Israel H. Weiner, M.D.*, Baltimore City

* There are currently three vacancies for 4-year term positions on the Board (6/30/92 to 6/30/96). Faculty bylaws require that Med Chi submit a list of physicians to fill vacancies on the board.

Awards Presented During 1992 Annual Meeting

Clifford Andrew, M.D. was the recipient of the Wyeth Ayerst Laboratories Physician Award for Community Service. Dr. Andrew received the award for his efforts to protect Anne Arundel County's natural resources through the Severn River Association.

Med Chi president *J. David Nagel, M.D.* presented certificates of recognition to the following three physicians for their outstanding service and dedication as chairpersons of Med Chi committees:

Edward J. Kowalewski, M.D., chairperson, Focused Professional Education Committee

Hiroshi Nakazawa, M.D., chairperson, Public Relations Committee

Ronald J. Cohen, M.D., chairperson, Peer Review Management Committee

Dr. Nagel also announced the winners of the 12th Annual Med Chi Photo Contest:

Michael A. McClinton, M.D. —First Place *David Paul, M.D.* —Second Place

Med Chi Student Component Society president *W. David Sullivan* was presented with the Award for Excellence in Organized Medicine in recognition of his outstanding accomplishments.

Dr. Nagel and MMJ Editor *Victor H. Hrehorovich, M.D.* presented commemorative covers of the MMJ to dean emeritus of the University of Maryland School of Medicine, *John M. Dennis, M.D.* (June 1992 cover), and current dean, *Donald E. Wilson, M.D.* (December 1991).

Also during the meeting, Dr. Nagel named Maryland Senate president *Thomas V. "Mike" Miller* as citizen of the year and presented him with the Henry and Page Laughlin Award for Citizenship.

HCFA 1500 Claim Form

Department of Health and Human Services secretary *Louis Sullivan, M.D.* has extended the grace period for using the old HCFA 1500 form until July 1, 1992. However, HCFA is currently accepting the new form and encourages physicians to

begin using it. The revised HCFA 1500 claim forms can be purchased by calling the AMA's Customer Service toll-free number, 1-800-621-8335.

Medicare Coding Update

In February 1992, HCFA instructed carriers to drop the HPBs (historic payment bases) for mycotic nails (procedure codes 11700 - 11711) and instructed carriers to make payments based on the 1992 fee schedule amounts.

Medical Hazardous Waste Disposal Facilities

Browning Ferris International has facilities at the following locations:

Anne Arundel/Howard County
7521 Cemetery Lane
Elkridge, MD 21227
(410) 799-7822

Baltimore District
68th Street at Pulaski Hwy.
Baltimore, MD 21237
(410) 686-6161

Central Maryland District
Route 2 - Box 327B
Hagerstown, MD 21740
(301) 662-1040

Eastern Shore
U.S. 13 North at Days Inn
Salisbury, MD 21801
(410) 749-1551

Montgomery County
3310 Kennilworth Avenue
Hyattsville, MD 20781
(301) 588-6575

Potomac District
8301 Beechcraft Avenue
Gaithersburg, MD 20879
(301) 417-0100

Washington/Maryland Metro
8401 Truck Way
Capital Heights, MD 20743
(301) 336-1000

Hagerstown/Western Maryland
11710 Greencastle Pike
Hagerstown, MD 21740
(301) 223-7272

MedX, another company that hauls biohazardous waste, requests that you call their 1-800-527-0666 number, follow the voice mail instructions, and someone will then take your zip code and have a salesperson get back with you.

To order biohazardous labels, you may contact the following companies who have sent the Faculty information concerning the availability of these labels:

American Health & Safety, Inc.
6250 Nesbitt Road
Madison, WI 53719
1-800-522-7554 FAX 1-800-326-3245

Carlton Industries, Inc.
P. O. Box 280, Hwy. 71 West
La Grange, TX 78945
1-800-231-5988

Requests for Claim Reviews—Maryland Blue Cross/Blue Shield

Usually, claim reviews require additional information and, therefore, the request for review should be done in writing. In order to ensure quick processing of your inquiry

- Use the Information Request Form (IRF)
- Attach a copy of the claim in question
- Include documentation (medical records, op notes, etc.) that will help to substantiate your request for review
- Do not send a second inquiry until the carrier has responded to the first inquiry

There are times when a telephone inquiry is appropriate to request review of a claim. Listed below are the most frequently requested changes and how they must be handled:

Telephone Request Accepted
Date of Injury (if omitted on claim)
Patient's Birthdate (birth year change)
Date of Service (year change only)
Place of Service Code
Patient's Name

Written Documentation Required
Date of Injury (if changing)
Patient's Birthdate (entire birthdate)
Date of Service (entire date changing)
Date of Service (Vision Claims)
Frequency of Service
Charges
Diagnosis
Procedure Code
Anesthesia Time

*Provider Payment/
Denial Appeal
Process—Maryland Blue
Cross/Blue Shield*

If you disagree with a claim determination and need to have it reviewed, there are three steps to follow. They are

Step 1. CONTACT THE PROVIDER INQUIRY SERVICE DEPARTMENT

By Phone —

If the payment/denial error is obvious and easy to explain, such as an omitted charge or a charge was listed incorrectly, the claim review may be requested by calling the Provider Assistance and Relations Account Team Number.

Account Team Name	Team Code	Name of Acct. Exec.	Local Number	800 Number
INSTITUTIONAL				
Central Maryland	A	Sharon Pettaway	581-3540	800-872-4025
Central Maryland	B	Debbie Wienecke	581-3576	800-544-2279
Eastern Maryland	T	Iris Jones	581-3566	800-628-5647
Western Maryland	T	Iris Jones	581-3566	800-628-5649
PROFESSIONAL				
PROF.-Eastern Shore	A	Joan Bennett	581-3567	800-628-5648
PROF.-Western MD	B	Bennett/Marshall	581-3567	800-628-5650
PROF.-Southern MD	C	Carol Marshall	581-3567	800-626-4113
Surgical/Anes.				
Baltimore City	D	Susan Williams	581-3581	800-437-2331
Metro Counties	E	Susan Williams	581-3581	800-437-2332
OB/GYN & Peds	F	Susan Williams	581-3581	800-438-2320
Therapies-PT/Chiropractic	G	Marie Snyder	581-3578	800-437-2321
Laboratory/Radiology	H	Cindie Pollock	581-3575	800-437-2322
Medical/Medical Specialties	I	Kate McCracken	581-3579	800-437-2325
Ancillary Health Care	J	Cliff Franklyn	581-3577	800-437-2328
DME - Home Health Care - IV Infusion Therapy - Vision Care				
Mental Health	K	Marie Snyder	581-3578	800-437-2330
Billing Agents	L	Grace Hooper	581-3572	NONE
Multi Specialty Groups - Sinai Professional				
Non-Par and Others	M	Marie Snyder	581-3530	NONE
Dental	M	Rosa Nagle	351-3541	800-272-1580
Hopkins, University, CPPA - Shock Trauma	N	Grace Hooper	581-3572	NONE

In Writing —

If a corrected claim, operative notes, or pathology reports are necessary, please send these items to: Par Correspondence, P.O. Box 811, Owings Mills, MD 21117. Include any information that will help explain the situation.

Requests for claim reviews must be received within 60 days from the date of the provider voucher.

Step 2. MEDICAL REVIEW

If a provider wishes to appeal the determination resulting from Step 1, a written request should be made for the claim to be reviewed by the Medical Review Department. (Send request to: Par Correspondence, P.O. Box 811, Owings Mills, MD 21117.) Again, pertinent claim information, such as operative notes, pathology reports, and photographs for certain plastic surgeries, should accompany the request for the claim review.

Step 3. REFERENCE AND APPEALS COMMITTEE

If a provider wishes to appeal the determination resulting from Step 2, a written request should be made for the claim to be reviewed by the Reference and Appeals Committee. (Send request to: Par Correspondence, P.O. Box 811, Owings Mills, MD 21117.)

Based on the recommendation by the Subcommittee on Immunizations and Infectious Diseases, Med Chi's Council approved of the recommendation that all infants, regardless of HBsAg status of the mother, should receive hepatitis B vaccination. Hepatitis B vaccine should be incorporated into vaccination schedules for children. The first dose can be administered during the newborn period, preferably before the infant is discharged from the hospital, but no later than when the infant is 2

*Universal Vaccination of
Infants Born to
HBsAg-Negative Mothers*

months of age (Table 1). Because the highest titers of anti-HBs are achieved when the last two doses of vaccine are spaced at least 4 months apart, schedules that achieve that spacing may be preferable (Table 1). However, schedules with 2-month intervals between doses, which conform to schedules for other childhood vaccines, have been shown to produce a good antibody response (Table 1) and may be appropriate in populations in which it is difficult to ensure that infants will be brought back for all their vaccinations. The development of combination vaccines containing HBsAg may lead to other schedules that will allow optimal use of combined antigens.

Special efforts should be made to ensure that high levels of hepatitis B vaccination are achieved in populations in which HBV infection occurs at high rates among children (Alaskan Natives, Pacific Islanders, and infants of immigrants from countries in which HBV is endemic).

Physicians should note that Medical Assistance will pay for the vaccine.

TABLE 1. Recommended schedules of hepatitis B vaccination for infants born to HBsAg* negative mothers

Hepatitis B vaccine	Age of Infant	Hepatitis B vaccine	Age of Infant
Option 1		Option 2	
Dose 1	Birth-before hospital discharge	Dose 1	1-2 months ⁺
Dose 2	1-2 months ⁺	Dose 2	4 months ⁺
Dose 3	6-18 months ⁺	Dose 3	6-18 months ⁺

* HBsAg = Hepatitis B surface antigen.

⁺ Hepatitis B vaccine can be administered simultaneously with diphtheria-tetanus-pertussis, Haemophilus influenzae type b conjugate, measles-mumps-rubella, and oral polio vaccines at the same visit.

(Morbidity and Mortality Weekly Report, Nov. 22, 1991, Vol. 40)

MTA Reduced Fare and Paratransit Program

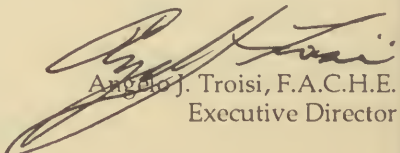
In July 1992, the Mass Transit Administration (MTA) will begin recertifying individuals for its Disability Reduced Fare and Paratransit programs. These programs allow individuals to use MTA services for a reduced fare or to use a special curb-to-curb service if they are unable to make use of main-line transit services. Over the next six to seven months, it is expected that close to 40,000 individuals will be contacting their physicians for assistance in completing the certification applications. The presence of a disability does not automatically qualify a person for the assistance programs; the application must state the degree of disability and how it affects the person's ability to travel. For a booklet describing the exact criteria or for more information, contact Gary Blanchard at 410-333-3360.

Med Chi Physicians Can Access Maryland Elder C.A.R.E.

Beginning July 1, 1992, Med Chi physicians can access Maryland Elder C.A.R.E., a program that recommends options for your elder care needs. The program, which is not available to the general public, offers

- a personalized assessment of your relative's needs by experienced gerontologists
- information on resources for your elderly relative, and
- access to more than 3,000 local and regional gerontological resources.

Med Chi members who use Maryland Elder C.A.R.E. pay a service fee of \$125 for a professional phone consultation. In person consultations are \$95/hour. To use this service, call 1-800-734-7545 and identify yourself as a Med Chi member.


Angelo J. Troisi, F.A.C.H.E.
Executive Director



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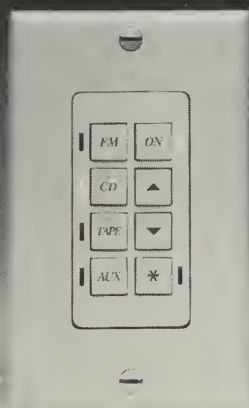
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Editorial

Medical education: The role of the *MMJ*

Forty years after its formation in 1799, the Medical and Chirurgical Faculty of Maryland inaugurated the publication of a medical journal "devoted to the interest of medical science," the purpose of which was to contribute to the continuing medical education of physicians in the state. Because of inadequate pecuniary support, the journal suffered a demise in 1843, but resumed publication in 1877. ■ Publication of the journal ceased again in

1918, but was revived in 1952 and exists today as the *Maryland Medical Journal (MMJ)*. Currently, the value of the *MMJ* as a useful tool in continuing medical education, and even the advisability of continuing its publication, is being questioned by some Med Chi members. These are critical issues that the Editorial Board of the *MMJ* must evaluate and act on.

Continuing education is part of the lifestyle for physicians who are constantly striving to improve and expand their medical expertise in the interest of excellent patient care. Various methods for continuing medical education exist, including attendance at lectures, seminars, society meetings, and hospital meetings; the use of audiovisual tapes; and the reading of medical journals. Attending some of these programs of continuing medical education requires significant expense in tuition, travel, and lodging, as well as the loss of practice revenue for physicians who choose to attend the meetings, seminars, courses, and conferences offered. Of course, by virtue of location, some programs offer the additional benefit of a limited vacation.

Medical journals obviate those expenses and have long been a significant way for physicians to continue their education. It is difficult, if not impossible, for a journal to have equal appeal to all physicians at all times, but most physicians have their journal favorites which they read on a regular basis.

In the past several decades, there has been a

virtual explosion in the number of journals available to physicians. Some journals are of a general nature, some are for special interest groups, some are sent freely, and others are sent only by subscription. Included in this selection are journals published monthly by thirty-six of the state medical societies, some of which focus more on legislative or administrative issues than on medicine. All, however, compete for a limited supply of excellent material.

In this expansive array of medical journals, what is the present role of the *MMJ*? I believe that its role should remain essentially the same as was proposed at its beginning—to contribute to the continuing medical education of physicians, particularly those in the state. This was clearly stated by the founding fathers in 1839.

Our course shall be fair and open; our object and desire is to afford another medium through which our junior members, in association with their aged and more experienced brothers, may have an opportunity of spreading before the public the result of their labor and reflections.¹

This can best be done by striving to present information that is accurate, well written, and of use to our readers. In addition, we would like to promote the *MMJ* as a vehicle for local physicians, medical institutions, and medical educators to use in their efforts to provide useful information to the medical community. All prospective authors should be encouraged by the knowledge that their material will be subject to peer review before acceptance and, therefore, can be a legitimate addition to their curriculum vitae.

Perhaps, once again, the intent of your present editorial board can best be expressed by quoting from the "Address of the Editorial Committee" to the membership of the society in 1839.

Of our individual talent for the work we can say nothing; our paper must speak for us in this particular. We, however, pledge our best ability to sustain the undertaking until those who called us to the post shall have an opportunity to pass upon our work, and either continue us in the relation we now hold to them or supersede us by the appointment of others better qualified to meet their views and wishes.

We cheerfully undertake the duties imposed upon us

because we believe that we shall not be left to contend, single-handed, for the object in view. Having a claim for assistance upon our brethren throughout the city, State and United States, we doubt not *they* will *as promptly* meet *that claim* as we have *pledged ourselves* to our work. To them we now make our appeal, confident that it will be responded to with promptness, and the pages of our ensuing numbers enriched by their contributions.¹

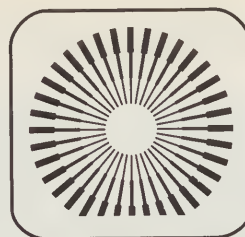
Recent issues of the *MMJ* or articles published in the *MMJ* have been sponsored by some of our community hospitals, medical organizations, and medical schools. The University of Maryland is the sponsor of this issue. The editorial board would like to have articles submitted more often from the extensive medical resources and talent in Maryland, to encourage greater utilization of the *MMJ* for publication of the work and experiences of Maryland physicians, and to provide a forum for them to contribute toward the continuing education of all of the physicians in Maryland. The *MMJ* should also present timely articles on medical practice issues and matters of legislative importance to our membership.

A recent survey of our readers has identified areas of interest that the editorial board will strive to satisfy. The editorial board is committed to making the *MMJ* a worthwhile instrument for continuing medical education—a journal that will appeal to the varied interests and needs of our readers. Toward that end, we invite your critical analysis and suggestions.

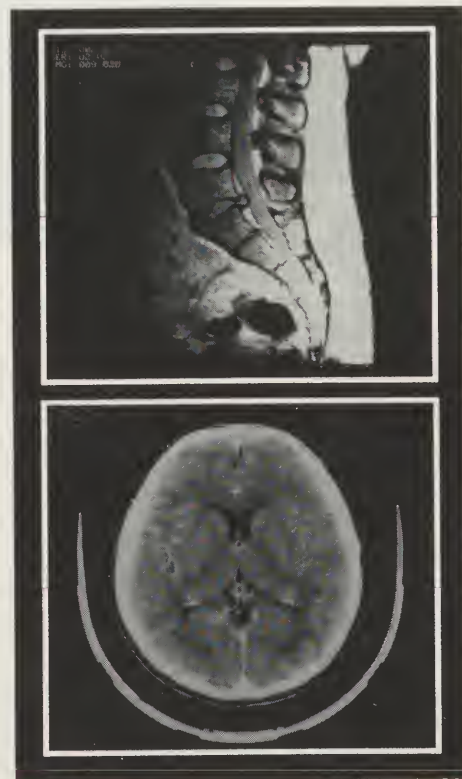
Reference

1. Cordell EF. The Medical Annals of Maryland—1799-1899. Baltimore: Williams & Wilkins Co. 1903; 98-100.

FRED J. HELDRICH, M.D.
Baltimore



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Antimony and Cleopatra

Bart Gershen, M.D.

In the December 1991 *MMJ*, we discussed the origin of the term **amino acid**. You may recall that it evolved from **ammonia** which, in turn, derives rather circuitously from the ancient Egyptian sun god **Ammon**. The word **acid** entered our language through the Latin *acere* 'to be sour', the adjective of which is *acidus* 'sharp or sour'. *Acere* also resulted in another term: *acetum* 'vinegar', the acrid taste of which originates from **acetic acid**—a phrase you should immediately recognize as the height of redundancy. As Latin developed into French, *acere* became *aigre* which also means 'sour'. *Vin aigre* means 'sour wine'—vinegar.

The Latin *acere* (sour or sharp) stems from *acus* 'needle' as in **acupuncture**. One with clinical **acumen** is a 'sharp' physician, and one with **acute** hearing has very 'sharp' auscultatory skills. (An **acute** angle is quite pointed, and a patient with an **acute** abdomen has a stabbing bellyache.)

The opposite of an acid, which yields a proton, is an alkali, which provides a complementary electron. The origin of the term **alkali** is somewhat convoluted. Ancient people did not have soap. The closest they came to such cleansers was a combination of certain oils mixed with an abrasive material. The abrasive was prepared by burning certain grasses and woods, placing their ashes into a pot of water, pouring off the undissolved solids, and boiling the remaining mixture. After the water had completely evaporated, the residual ashes were removed from the pot, heated together with oils, and this unique compound was used for cleaning. The Arabs called the ashes *al quili* 'plant ash'—which, in English, became **alkali**.

The ashes were also called **pot ashes** or simply **potash**. In 1807, a British chemist, Sir Humphry Davy, passed an electric current through molten potash and recovered an unusual metal. He designated the element from its source, calling it **potassium**. Much later, other scientists decided to give it a more Latinized name. They named it **kalium** from **alkali**—hence providing us with the chemical signature "K." (Incidentally, **potash** is principally composed of potassium hydroxide.)

In 1808, Davy once again made an elemental discovery. He heated limestone and recovered a metal that he promptly named **calcium** from the Latin word for limestone *calx*. (Limestone is mainly CaCO_3 . Heating it drives off CO_2 , leaving residual calcium.)

A small stone or pebble was called a **calculus**. In ancient times, people did arithmetic by using a counting board known as an *abax*. By stringing pebbles into rows and sliding the stones back and forth as you counted, one could easily add and subtract large numbers. The *abax* is now known as an **abacus**, and mathematics is done by calculation. In 1684, two friendly scientific rivals simultaneously developed a new mathematical system. Sir Isaac Newton and Gottfried Wil-

helm Leibniz each separately published the method. It was called the **calculus**. Their friendship subsequently dissolved.

A yet more primitive method of counting involves the use of fingers (and toes). Since the Latin for this part of one's anatomy is known as a *digitus*, the numbers derived were called **digits**. Today we have something called a **digital calculator** which incorporates neither fingers and toes nor stones.

A kidney stone is logically called a **calculus**. And certain metabolic states—such as primary hyperoxaluria—cause a disorder known as **nephrocalcinosis**. However, true to the inconsistencies of language, a stone within the renal pelvis or ureter is known as nephro/uretero—**lithiasis** (Greek *lithos* 'stone'), and surgery to remove it is called a **lithotomy** (Greek *tome* 'a cutting', as in **anatomy**—"to cut up.")

Indeed, a **lithograph** is a picture (Greek *graphein* 'to write') created by designs that are cut into flat stones (or now, more fashionably, flat metal plates). And the archaeological period known as the Stone Age is referred to as the **Paleolithic**, **Mesolithic**, or **Neolithic** era (Greek *palaaios* 'ancient,' Greek *mesos* 'middle,' and Greek *neos* 'new'). **Megaliths** are giant (Greek *megas* 'huge') stones used in ancient monuments, such as those on Easter Island or at Stonehenge. A **monolith** (Greek *monos* 'single, alone') is a statue or obelisk carved from one stone. (A monolithic philosophy is metaphorically one which has a uniform, inflexible character.)

The element **lithium** was discovered in petalite stone by Swedish scientist Johan August Arfwedson in 1817. (Petalite is lithium aluminum silicate.)

The **os calcis** or **calcaneus** is, of course, the heel bone—named for its resemblance to a large stone. When heel spurs develop, perhaps we should refer to them as **calculi** of the **calcis**.

In ancient Egypt, women—such as the ravishing Cleopatra—applied a fine antimony powder to their eyelashes in order to entice suitors. (Antimony and Cleopatra?) This was called *al koh'l*—Arabic for powder of antimony. In the sixteenth century, chemists used this same term to describe the fine vapors of steam that rose from heated liquids. Wine is a mixture of water and other fluids that boil at much lower temperatures. When wine is heated, its vapors can be collected in cool glass tubes, yielding highly concentrated drops of that other chemical. The process is called **distillation** (Latin *de* 'down' + *stillare* 'to drop'.) The apparatus is sometimes referred to as a "still" for short. The stuff that comes out, we call **alcohol**.

Wine was known as *methy* in ancient Greece. Wood was called *hyle*. Therefore, wood alcohol (or wine) was known as *methy* + *hyle* or **methyl**. Today, we know its chemistry consists of CH_3 groups. We also appreciate that wood alcohol

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is not safe to drink. The ancients, however, had another method of protection against the toxic effects of their libations. They believed that a lovely purple jewel worn about the neck—or, perhaps, fashioned into a drinking glass—would safeguard them from old John Barleycorn. They termed this precious stone **amethyein**—a ‘not’ + methyein ‘intoxicated’ (derived from *methy*).

We know it as **amethyst**. ■

MEMBERS IN THE NEWS MEMBERS IN T



James P.G. Flynn, M.D. has been named director of Corporate Rehabilitation Services for the University of Maryland Medical System. In his new position, Dr. Flynn will work to increase the referral base and develop new programs for the University of Maryland Rehabilitation Network.

Prior to his appointment, Dr. Flynn completed a two-year term as director of the Maryland Institute for Emergency Medical Services Systems. He was also the former chief executive officer and medical director of Montebello Rehabilitation Hospital.

In 1990, Dr. Flynn was named the National Rehabilitation Association Mid-Atlantic Administrator of the Year. In 1988, he was the recipient of the Louis L. Goldstein rehabilitation award. Dr. Flynn has participated in a number of national task forces and workshops pertaining to rehabilitation.

Dr. Flynn is a clinical professor in the Department of Neurology and an associate professor in the Department of Epidemiology and Preventive Medicine of the University of Maryland Medical Center. He is also an adjunct professor in the Department of Emergency Health Services of the University of Maryland Baltimore County. Dr. Flynn is a surveyor for the Commission on Accreditation of Rehabilitation Facilities (CARF). He is a fellow of the American College of Physicians and a fellow of the College of Chest Physicians.

Dr. Flynn received his medical degree with distinction in medicine from Trinity College, Dublin University. He trained at the Johns Hopkins Hospital, Baltimore City Hospitals, Greater Baltimore Medical Center, and the Maryland Department of Health and Mental Hygiene. He earned masters degrees from Trinity College and the Johns Hopkins University School of Hygiene and Public Health. ■



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Benjamin F. Trump, M.D.

Dr. Trump is professor and chairman, Department of Pathology, University of Maryland School of Medicine.

To honor John M. Dennis, M.D., dean emeritus of the University of Maryland School of Medicine, the faculty have assembled a series of papers to be included in the June and July issues of the *Maryland Medical Journal*. Dr. Dennis' term as dean (1973-1990) was a critical period for the School of Medicine and for new developments in biomedical science, especially in the application of cellular and molecular biology concepts and techniques to clinical medicine. During Dr. Dennis' tenure, the School of Medicine grew considerably, establishing itself in the forefront of US medical schools in the areas of research, teaching, and clinical science. Much of the credit for this rapid and prodigious development goes to Dr. Dennis who, through a remarkable series of recruiting efforts and expansion of building and other resources, was able to lead the School of Medicine to its present status.

In putting together this tribute to Dr. Dennis, the strategy was to obtain a paper from each department in the School of Medicine and a paper recounting the development of the University of Maryland Medical System. Perusal of these articles will highlight the development of biomedical science at the University of Maryland Medical School and the University of Maryland Medical System under the administration of John M. Dennis, M.D. ■

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Comments on John M. Dennis, M.D.

Donald E. Wilson, M.D.

Dr. Wilson is professor of medicine and dean, University of Maryland School of Medicine.

The transition between the administrations of Dean Emeritus John M. Dennis, M.D., Acting Dean Richard D. Richards, M.D., and my administration has been greatly facilitated by the presence of a world class faculty, an excellent student body, and an academic environment that promotes scholarship, innovation, and academic integrity. The basis for this environment has been the diligent stewardship of John Dennis during the sixteen years that he served as dean of the School of Medicine. At the time of Dr.

Dennis' retirement in 1990, the School of Medicine had moved into the top 20 percent of state-supported US medical schools in research funding. In FY1991, the School of Medicine's increase in National Institutes of Health (NIH) funding ranked first of all state-supported medical schools at 23 percent, and second of all US medical schools—public and private.

In the eight months that I have been dean, the School of Medicine has suffered severe budget cuts, furloughs of faculty and staff, and gloomy forecasts. Yet, our resiliency has allowed us to remain strong and, in fact, prosper. I thank Dr. Dennis for having the foresight and skill to build such a diversely strong faculty. His ongoing dedication to the School of Medicine and to Maryland continues to make my job easier. John Dennis is still working on behalf of the School of Medicine. In addition to being available for consultation, he is spending a portion of his time as a fund-raiser for the medical school. This activity is extremely im-

portant, given the recently announced fund-raising campaign of the University of Maryland Hospital and the School of Medicine.

Personally, I have found John Dennis to be warm and helpful. This is particularly important to a new dean. I look forward to his continued support and assistance in the years to come and wish him all the best in his richly deserved retirement. ■



Dr. Wilson (l) congratulates Dr. Dennis on his seventeen successful years as dean of the School of Medicine.

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John M. Dennis, M.D., Dean of the University of Maryland School of Medicine: 1973-1990

Richard D. Richards, M.D. and Benjamin F. Trump, M.D.

From the University of Maryland School of Medicine where Dr. Richards is professor and chairperson, Department of Ophthalmology; and Dr. Trump is professor and chairperson, Department of Pathology

John M. Dennis, M.D. was dean of the University of Maryland School of Medicine for 17 years. His numerous accomplishments in that role will have a positive effect on the future of the School of Medicine for years to come.

Dr. John Dennis finished an extraordinary 17-year tenure as dean of the University of Maryland School of Medicine on June 30, 1990. During that time, remarkable changes occurred at the University of Maryland Medical School as a result of his vision and actions. The school had long been known for its emphasis on clinical education of medical students. Dr. Dennis fostered and developed a climate for research, both basic and clinical, and the school became known for its research efforts in addition to its clinical activities. As the only two department chairpersons present both before and during Dr. Dennis' entire tenure, we were privileged to participate in these changes and are pleased to recount our view of the impact of Dean Dennis on the University of Maryland School of Medicine.

Dr. Dennis was perhaps an unlikely prospect to serve as dean but, fortunately, circumstances developed that pointed him in that direction. The faculty and the alumni remain appreciative for those circumstances. Dr. Dennis was born on the Eastern Shore, and spent his entire professional career at the University of Maryland. He received his B.S. in 1943 from the University of Maryland College Park, and his M.D. from the University of Maryland School of Medicine in 1945. His internship was at the University of Maryland Hospital, as was his residency in radiology which he completed in 1950. Between graduation and completion of his residency, he spent two years in the armed services, during which time he was chief of radiology at a US Air Force base hospital. After his residency, Dr. Dennis spent one year as a fellow at the Hospital of the University of Pennsylvania. He then returned to the University of Maryland School of Medicine, first as an instructor and then as an associate professor in the Department of Radiology from 1951-1953.

In 1953, the position of chairperson became vacant, and the dean of the medical school, Dr. H. Boyd Wylie, recognized the potential of John Dennis and named him professor and chairperson of the Department of Radiology. Dr. Dennis was the first full-time chairperson in the medical school, although Theodore Woodward, M.D. was the first full-time faculty member (appointed in 1948) in the Department of Medicine. Dr.

Dennis was chairperson of the department from 1953 to 1974. During that time, he developed strong ties with his fellow radiologists and became involved in leadership positions with national radiological organizations. He was particularly active in the American Board of Radiology and the American College of Radiology, serving as president of the latter from 1976 to 1977. He continued his activities with these groups throughout his terms as chairperson and as dean. Dr. Dennis was recognized as a national leader in the field of radiology and received a number of honors from these organizations.

As chairperson of the Department of Radiology, he served for 2 years under Dean H. Boyd Wylie, M.D. and then under Dean William S. Stone, M.D. from 1955 to 1969. Dr. Stone was brought to the University of Maryland by President Harry Byrd during a time of academic difficulties for the School of Medicine. Dr. Stone was responsible for continuing the move to full-time departmental chairpersons and faculty, with limited state support. During this time, Dr. Wilson Elkins became president of the university and he continued to provide support for the medical school by appointing Albin Kuhn, M.D. as chancellor for the University of Maryland at Baltimore (UMAB) campus. Dr. Dennis and Dr. Kuhn worked closely on Dr. Dennis' plans for the development of the Department of Radiology.

In 1969, John H. Moxley III, M.D. was appointed dean—a position he held until 1973. This was a period of campus development during which several new department chairpersons were appointed. During this early growth phase, Dr. Moxley was successful in developing plans for the Medical School Teaching Facility.

In 1973, with the departure of Dr. Moxley, Dr. Dennis was named acting dean. Following a search for a permanent dean and a review of the proposed candidates, Chancellor Kuhn appointed John M. Dennis, M.D. as dean in 1974. Having been chairperson of the Department of Radiology for 20 years, Dr. Dennis had a clear understanding of the difficulties the School of Medicine had gone through. He recognized that the key to progress and stability for the school was the appointment of chairpersons and faculty who shared his vision of the role of research in a medical school. Although this was a time during which funds were available through the National Institutes of Health (NIH), Dr. Dennis was also successful in working with Chancellor Kuhn to increase support from the state of Maryland. Chancellor Kuhn and Dean Dennis developed



Dr. Dennis with his family: From left to right, Anthony Ranieri, M.D. and his wife, Lori Ranieri (daughter); John Dennis, M.D. and his wife, Mary Ellen Dennis; Terry Passano (daughter) and her husband, William Passano; John M. Dennis, Jr., S.J. (son); and Sherry Dennis and her husband, Patrick Dennis (son).

effective relationships with the governor and state legislators, who responded by recognizing the strength of Dean Dennis' leadership and the importance of supporting the School of Medicine.

During his 17 years as dean, Dr. Dennis recruited department chairpersons for all of the departments within the medical school with the exception of two; some chairs he even filled a second time. Starting with the basic science departments, he recruited chairpersons who had enthusiasm and excellent research backgrounds, supporting them in the development of their departments and in the recruitment of young faculty. By 1990, the number of full-time faculty had grown to almost 900, with approximately 350 supported by state funds. The rest of the faculty were supported by the increasing funds provided by grants, contracts, and other outside sources.

Dr. Dennis also recruited, for clinical departments, chairpersons who had an interest in research and who had backgrounds enabling them to develop effective and extensive research programs through the recruitment of appropriate faculty members. In the last year of his tenure as dean, the American Association of Medical Colleges ranked the University of Maryland Medical School number 13 in the amount of NIH peer-reviewed, grant support provided to the 74 public medical schools, and number 33 in the amount of support provided to all 126 medical schools. During that year, the University of Maryland Medical School chalked up the greatest percentage increase in NIH funding of any public medical school and was second only to the University of Southern California

among all medical schools. This achievement, accomplished in a climate of fiscal restraint and competition, is only one measure of Dr. Dennis' success in developing the school's research activities.

Dr. Dennis also pushed hard for the replacement of the Loch Raven Veterans Administration (VA) Hospital with a new facility on the campus of the University of Maryland at Baltimore. In 1970, planning began, and in 1979, the VA purchased land adjacent to the University of Maryland Hospital for its new location. The contract was awarded in 1980, but was incomplete at the time President Reagan took office.

John Dennis did not give up hope on the fulfillment of the building contract, but worked diligently through the years to ensure completion of the VA hospital on the UMAB campus. He worked with the Maryland congressional delegation and veterans groups, and he has given a great deal of credit to then US Senator Mathias for gaining the Maryland delegation's support of the proposed VA hospital. Dr. Dennis persevered and was rewarded by being able to participate in the groundbreaking ceremony for the new VA hospital. At this time, the new VA hospital is almost completed and all patients will be moved from the Loch Raven Veterans Administration Medical Center (VAMC) to the new VAMC in November of 1992.

While dean, Dr. Dennis held other titles including vice chancellor of Health Affairs, vice president for Academic Affairs, and acting chancellor of the University of Maryland at Baltimore from April to December of 1984. He worked closely with Chancellor Kuhn, with Chancellor Farmer who succeeded Chancellor Kuhn, and with Chancellor Brandt. Dean Dennis started the graduate school while serving as vice president for Academic Affairs and was also responsible for the university's Grants and Contracts Office.

Dr. Dennis recognized the need for upgrading the existing research facilities and was able to institute a program of renovation for the John Eager Howard Hall. However, as the research activities on campus increased, lack of adequate space became a serious problem. With Dr. Marjorie Wilson, then senior associate dean, Dr. Dennis developed plans for a research building that would significantly expand the amount of research space available for faculty from all the health science professional schools on the UMAB campus. Although various methods of financing were explored, he was successful in

convincing state legislators that the state should erect this building.

He was able to accomplish this by showing the governor and state legislature how important the medical school was to the economic condition of the state, and the extent to which outside funds were brought in by the faculty of the School of Medicine. Although the University of Maryland School of Medicine is regarded as a state school, only 20–25 percent of the budget, at that time, came from state funds, with the remainder coming from outside sources.

While emphasizing the importance of becoming a medical school noted for research, Dr. Dennis did not neglect clinical activities. He strongly supported the clinical departments in the development of appropriate space for faculty practice. He also recognized the importance of the partnership between the medical school and the hospital, and developed, with Dr. Morton Rapoport, CEO of the University of Maryland Medical Systems, the concept of the medical center. The medical center system, now well accepted by both the hospital and medical school administration and faculty, has resulted in the development of a true partnership arrangement.

Dr. Dennis also recognized the need to continually review the medical school curriculum. He believed the faculty should be in charge of the curriculum, and always supported the faculty in this regard. At the same time, however, he encouraged recommendations for changes in the curriculum.

We now think in terms of strategic plans and planning committees. Dr. Dennis did not have a strategic planning committee nor a written strategic plan. However, he obviously had a strategic plan in his mind, and his vision was clearly articulated in his actions. His philosophy as a dean was to support his faculty in every way, but not to interfere with their progress as long as the progress was in the general direction that he considered appropriate. Since he appointed the chairpersons, he was careful to select those who had a vision similar to his own, and the end result was a very harmonious and progressive period of time. Few deans have had such an impact on medical schools as has John Dennis. By the same token, few medical schools have responded and progressed to the extent that the University of Maryland Medical School did during that time. ■

COMING OUT OF THE DARK

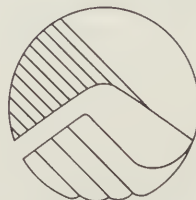
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Endogenous ouabain: Implications for cardiovascular disease diagnosis and therapy

Mordecai P. Blaustein, M.D. and John M. Hamlyn, Ph.D.

From the Department of Physiology, University of Maryland School of Medicine, where Dr. Blaustein is professor and chairman and Dr. Hamlyn is associate professor.

The remarkable discovery that ouabain (endogenous digitalis) is a hormone produced by the adrenal cortex raises important questions about the physiological actions of this substance and its role in the pathogenesis and therapy of cardiovascular diseases.

Two different lines of research recently converged to provide new ideas about sodium regulation and blood pressure—blood volume relationships in humans. One is the search for an endogenous counterpart to the cardiotonic steroids (digitalis glycosides) of plant origin which have been used to treat congestive heart failure for over two centuries and for which there are receptors (the sodium pump or Na,K-ATPase) on virtually all cells in the human body.¹ The second is the search for a mechanism to explain how excess dietary salt may lead to the elevation of blood pressure.^{2,3} Both searches have led to the purification and identification of a substance from human plasma that, astonishingly, is structurally and functionally indistinguishable from the plant-derived cardiotonic steroid and arrow poison, ouabain.⁴ This mammalian substance, which cross-reacts with anti-ouabain antibodies and inhibits the sodium pump (the digitalis receptor), is present in high concentration in adrenal glands and is secreted by cultured adrenal cortical cells.⁴ The sodium pump, which utilizes metabolic energy (in the form of ATP) to extrude sodium from cells so as to maintain a very low intracellular sodium concentration, is the only known receptor for ouabain. Therefore, we need to focus on the physiological consequences of sodium pump modulation in order to understand how ouabain works.

Possible role of ouabain in the pathogenesis of hypertension

A key question is whether ouabain is involved in the pathogenesis of human hypertension. Preliminary evidence indicates an affirmative answer.

In the first controlled study on the relationship between ouabain and hypertension, plasma ouabain levels were found to be much higher than normal in patients with acute hypothyroid-induced hypertension; indeed, blood pressure was directly correlated with the plasma ouabain level.⁵ Furthermore, blood pressure and ouabain levels both returned to normal when the patients were made euthyroid with thyroid hormone replacement therapy.⁵

A recent report⁶ indicated that 60 percent of Japanese with essential

Plasma volume expansion and blood pressure elevation

This raises a new question: How, precisely, does plasma volume expansion cause the blood pressure to rise? That is, what are the specific mechanisms involved? Mineralocorticoid hypertension appears to be a good model to address this question because high concentrations of mineralocorticoids initially cause salt retention and plasma volume expansion without blood pressure elevation. This early phase is, however, associated with very high plasma levels of a sodium pump inhibitor (EDLF; **Figure 3**),¹⁸ which implies that plasma volume expansion, by as yet unknown mechanisms, may trigger the secretion of ouabain. With maintained high doses of mineralocorticoids, there is a transient "escape" natriuresis. This is followed by a parallel rise of the plasma level of a sodium pump inhibitor and of blood pressure.¹⁸ The fact that the sodium pump inhibitor level rises before the blood pressure does, raises the possibility that the sodium transport inhibitor somehow causes the blood pressure to rise. Moreover, this observation may have very important clinical implications; detection of elevated ouabain levels in normotensive individuals with normal cardiac function may be a prognostic indicator for the later development of hypertension. In this regard, a convenient laboratory test to measure plasma ouabain levels is currently under commercial development.

How does ouabain elevate blood pressure?

Knowledge of the mechanism by which (plant-derived) ouabain can enhance vascular reactivity provided early justification to search for an endogenous ouabain as a missing factor in the pathogenesis of hypertension.^{2,3} In the heart, the plasma membrane sodium/calcium exchanger is the link that helps to explain how inhibition of the cardiac sodium pump increases delivery of calcium to cardiac muscle;¹ this increased intracellular calcium (most of it normally stored in the sarcoplasmic reticulum) is what actually augments contractions. Vascular smooth muscle cells also have a plasma membrane sodium pump and a sodium/calcium exchanger. In blood vessels, as in the heart, cardiotonic steroids, including human ouabain, increase the delivery of calcium to the smooth muscle cells and thereby augment the contractile responses to vasoconstrictors.^{2,19} Cardiotonic steroids also inhibit the sodium pump in vasoconstrictor nerve terminals in the vascular wall; this augments noradrenaline release and reduces re-uptake, thereby acting synergistically with the direct effects of cardiotonic steroids on the vascular smooth muscle.²⁰ Thus, the net effect of elevated plasma ouabain levels will be an increase in vascular tone (**Figure 2**). Initially, this will be offset by the cardiovascular reflexes (primarily the baroreceptor reflex) that tend to maintain the mean blood pressure within preset limits. Once the capacity of these reflexes is exceeded, however, mean arterial pressure will rise. This will induce a natriuresis that may compensate for the underlying tendency to retain salt and water. Thus, it appears that the body is normally adjusted to maintain a normal plasma vol-

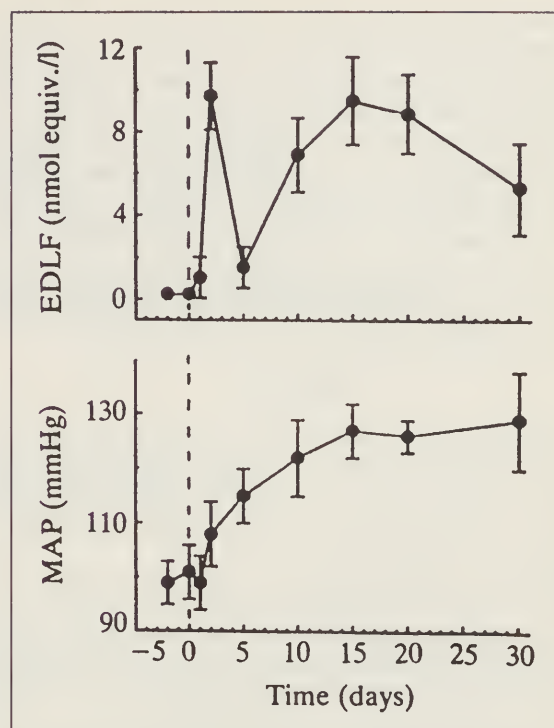


Figure 3. Time course of changes in mean arterial pressure (MAP) and the endogenous sodium pump inhibitor (EDLF) during the development of deoxycorticosterone acetate (DOCA) hypertension in the pig. The uninephrectomized pigs received silicone implants containing 100 mg DOCA/kg body weight on day 0 (broken vertical line). EDLF was determined by a human erythrocyte ouabain-sensitive ⁸⁶Rb uptake assay. Each point is the mean \pm SE of data from six animals. (Reprinted from Hamlyn JM. *Journal of Endocrinology* 1989; 122:409-20.)

ume even at the expense of an elevated blood pressure. In the majority of individuals with chronic hypertension, including those with essential hypertension, Conn's syndrome, and pregnancy-induced hypertension (and perhaps other forms of hypertension as well), plasma volume is normal or low-normal and obscures the evidence that the initiating event may have been a tendency to volume expansion.²¹ The mechanism(s) by which the volume expansion is detected and converted into the signals(s) that stimulate secretion of ouabain is (are) yet to be elucidated.

Other implications of endogenous ouabain

As described above, the discovery of endogenous ouabain may contribute to our understanding of the pathogenesis of hypertension; however, the implications of this discovery are much more far-reaching. Ouabain may play a role in modulating sodium pump activity in a variety of types of cells. The small changes in intracellular sodium may then be transduced, via sodium/calcium exchange, into relatively large changes in cell calcium, most of which is sequestered in intracellular organelles (especially the endoplasmic reticulum). The endoplasmic reticulum serves as a store for the "second messenger" calcium that mediates such processes (known to be affected by ouabain) as muscle contraction, secretion of

hormones and neurotransmitters, renal sodium reabsorption, visual adaptation, and cell division. In this way, ouabain may modulate cell responsiveness in many types of tissues under a large variety of conditions; indeed, this may be one of its major physiological actions.²² Finally, the role of digitalis therapy in congestive heart failure and other diseases will also require re-evaluation; for example, preliminary evidence indicates that ouabain levels are significantly elevated in patients with severe cardiac failure.²³ The discovery of endogenous ouabain opens up numerous physiological and pathophysiological processes to renewed exploration.

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The role of ionized cytosolic calcium ($[Ca^{2+}]_i$) in injury and recovery from anoxia and ischemia

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Cellular reaction to deprivation of oxygen and/or lack of substrate perfusion due to altered blood flow can be categorized in three phases: initiation, reversible, and irreversible or recovery.

The response to and recovery from injury are the major determinants of cell survival. An understanding of these processes will permit the design and implementation of a variety of medical technologies for the prevention, diagnosis, and treatment of all human disease.

Of all injuries to human cells, the most prevalent is deprivation of oxygen and/or lack of substrate perfusion due to altered blood flow. These injuries are responsible for the initiation of virtually all illnesses and death resulting from stroke, myocardial infarction, shock, trauma, diabetes, and hypertension. Cellular anoxia is also a major impediment to the radiation treatment of neoplasia and, if controlled, would assist in cancer chemotherapy.

For these reasons, our laboratory has been concerned for many years with understanding cellular reactions to these injuries, their impact on recovery, and the molecular mechanisms involved.¹⁻¹⁰ Our investigations have led us to the hypothesis that the critical events involve intracellular signaling—especially that involved with ion regulation (**Figure 1**). It appears that regulation of the intracellular ion Ca^{2+} is the most critical.^{2,6-10} This paper presents a summary of these experiments.

The responses to injury have been categorized as follows: initiation phase, reversible phase, and irreversible or recovery phase. These have been described previously and are summarized briefly below.^{1,2}

Initiation phase

The initiation phase of ischemia begins with the interruption of the blood supply to the cell, organ, or tissue at risk. The ischemia can be partial or complete, depending on the extent of vascular occlusion and the degree of collateral vessel development. For the purpose of the present discussion, we will confine our remarks to the effects of total ischemia.

With ischemia, oxygen levels in blood and interstitial tissues decrease to levels approaching zero as consumption by the surrounding cells proceeds. This soon leads to total anoxia and inhibition of mitochondrial respiration. Mitochondrial ATP (adenosine triphosphate) synthesis

ceases and the cell is totally dependent on anaerobic glycolysis for ATP synthesis. Depending on the cell and tissue type, temperature, and the amount of cellular glycogen present, ATP synthesis lasts for a variable period ranging from seconds to perhaps an hour in highly glycolytic cells replete with glycogen. Lactate and inorganic phosphate accumulate, reducing intra- and extracellular pH. These actions precede the events of the reversible and then the irreversible phases.

Reversible phase

Intracellular alterations begin immediately following the initiation phase. Reduction in cellular ATP and morphologic damages occur simultaneously in seconds. These changes combine to induce a sequence of structural and functional alterations, all of which are reversible if the blood supply is restored prior to the point-of-no-return. In the rat liver, human liver, or human kidney, this reversible phase has a duration of about 60 minutes at 37° C; in the heart, the reversible phase lasts only 15–20 minutes at the same temperature.

Morphologically, the changes in this phase are characterized by alterations in cell shape, changes in intracellular compartment volume, and complex nuclear and nucleolar alterations including clumping of chromatin. The changes in

cell shape are characterized by formation, at the cell surface, of large bleb-like protrusions that have a low refractive index and are relatively free of organelles.⁶ This blebbing represents a change in the interactions of cytoskeletal elements, including actin and tubulin, with the plasmalemma. The actin filaments detach from the surface plasmalemma forming a constrictive band at the base of the bleb. It is postulated that this constrictive band later contracts and seals off the membrane with the bleb detaching and floating into the extracellular space. Our studies indicate that bleb formation occurs when the concentration of cytosolic ionized calcium ($[Ca^{2+}]_i$) is greater than 300 nM.^{6,7} Bleb formation appears to involve Ca^{2+} -activated proteases which, among other factors, may modulate the cytoskeleton in this region.⁵ *In vivo*, these blebs may be important in obstructing the kidney tubule lumens in acute renal failure, in releasing hepatic enzymes such as SGPT (serum glutamic pyruvic transaminase) into the extracellular space, and in myocardial cell-cell interactions.

Other morphological changes in this phase include dilatation of the endoplasmic reticulum, changes in the mitochondria, and changes in the nucleus. The cisternae of the endoplasmic reticulum undergo dilatation that is often wide-

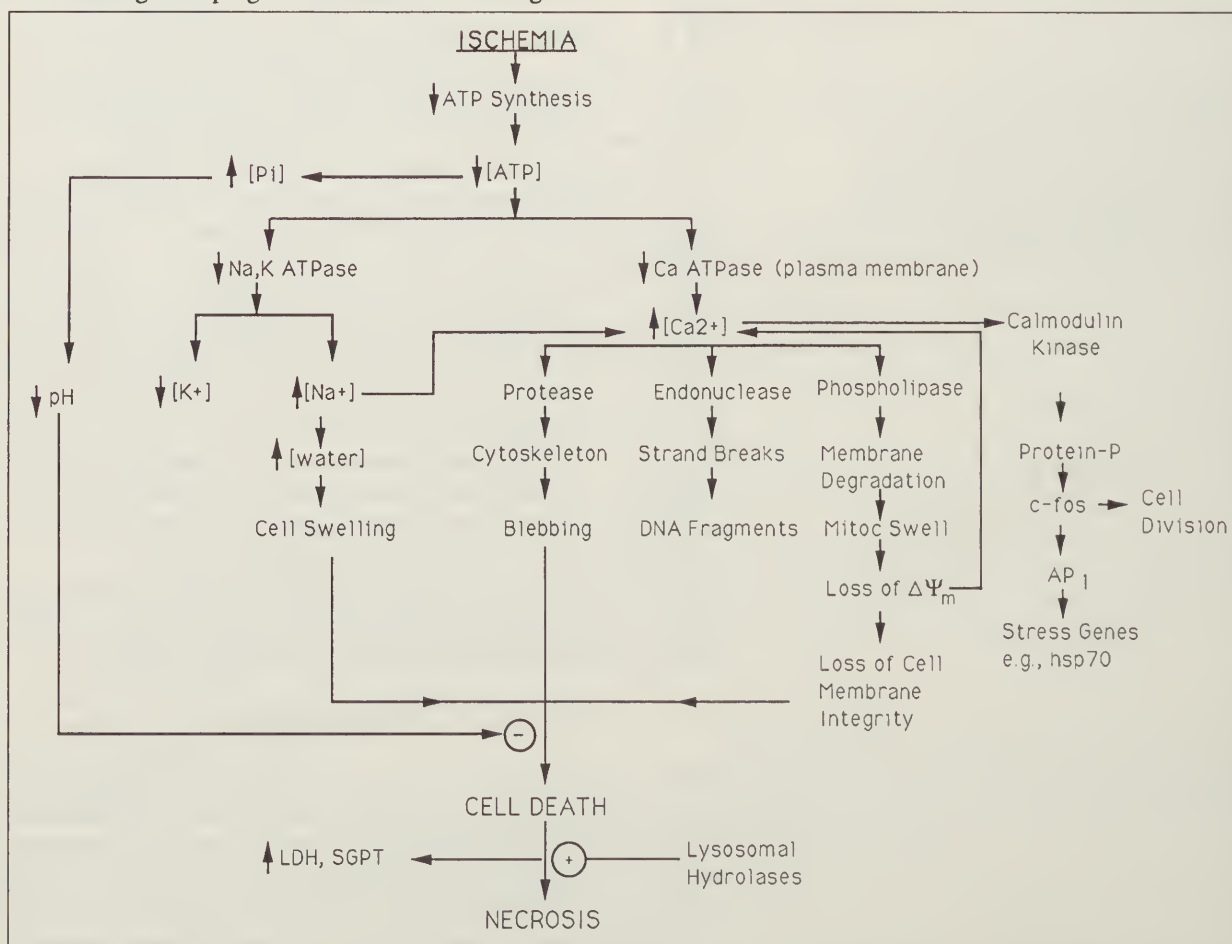


Figure 1. Flow chart representing our current working hypothesis concerning the relationships between ion deregulation and the progression of cell injury resulting from ischemia. Decreased ATP production leads to cessation of Ca^{2+} - and Na^{+}/K^{+} -ATPases accompanied by increases in cytosolic H^{+} , Na^{+} , and Ca^{2+} . The increased Ca^{2+} is detrimental, particularly through activation of proteases, endonucleases, and phospholipases.

spread and may result in small vacuoles in the cytoplasm and the cavity of the nuclear envelope. Initially, the mitochondria undergo condensation of the inner compartment and often loss of the normal mitochondrial matrix granules. Later, swelling of the mitochondrial inner compartments occurs. Changes of the nucleus involve very early clumping of chromatin which can occur within 5 minutes.

In the absence of ATP, ion translocating systems, such as Na^+/K^+ - or Ca^{2+} -activated ATPases, cease to function. This process is associated with increases of cytosolic Na^+ ($[\text{Na}^+]_i$), decreases of cytosolic K^+ ($[\text{K}^+]_i$), and increases of $[\text{Ca}^{2+}]_i$. $[\text{Ca}^{2+}]_i$ increases from 100 μM to 400–500 nM by approximately 1 hour as measured *in vitro* using rabbit proximal tubule epithelial cells treated with KCN plus iodoacetate to mimic ischemia by inhibiting both mitochondrial and glycolytic metabolism.⁸ Greater and more rapid increases in $[\text{Ca}^{2+}]_i$ are seen in the hepatocyte following treatment with KCN and iodoacetic acid (Figure 2).

This increased $[\text{Ca}^{2+}]_i$ appears to represent the mechanism for activation of a number of pathways that mediate both membrane damage and, ultimately, cell death while activating signaling pathways that play a role in gene activation preparatory to increased cell division and regeneration. These signaling pathways include Ca^{2+} -activated enzymes such as phospholipase A_2 , endonucleases, and proteases. Activation of phospholipase is associated with alterations of membrane phospholipids and release of fatty acids which, in turn, result in morphological changes such as mitochondrial swelling. Activation of Ca^{2+} -dependent endonucleases yields DNA single-strand breaks within the chromatin. These breaks occur in association with chromatin clumping. Ca^{2+} -activated

proteases or calpains can modify a number of substrates, including the cytoskeletal protein, actin, and its associated membrane-binding proteins. Calpain activation may represent the mechanism of action of bleb formation.⁵

Irreversible phase

Cell death occurs if the ischemic injury is prolonged further. Morphologically, this stage is characterized by further swelling of intracellular organelles, especially the mitochondria. Irreversible injury is heralded by the appearance of large aggregates of denatured protein within the mitochondrial matrix, often referred to as flocculent densities. At this point, the mitochondria are irreversibly damaged and cannot perform oxidative phosphorylation, presumably due to damage of the membrane. This results in the inability to maintain a proton gradient and, probably, uncoupling of ATP production. Biochemically, there is continued degradation of substrates in-

cluding lipids, proteins, and nucleic acids, and also the loss of cell membrane integrity. This degradation is evidenced by increased leakage of ions into or out of the cell and in the release of cytosolic enzymes, such as lactate dehydrogenase, into the medium. Enzyme leakage is the basis of diagnosis of necrotic areas in animals or patients as determined by the measurement of serum levels of enzymes such as creatine kinase, SGOT (serum glutamic oxaloacetic transaminase), and SGPT.

Necrosis results from the continued hydrolytic attack on all substrates. Lysosomal hydrolases, at this time, have access to all cytoplasmic substrates and gradually convert them to necrotic debris. A hallmark of this phase is increased eosinophilia of the cytoplasm due to protein denaturation and total degradation of chromosomal DNA (deoxyribonu-

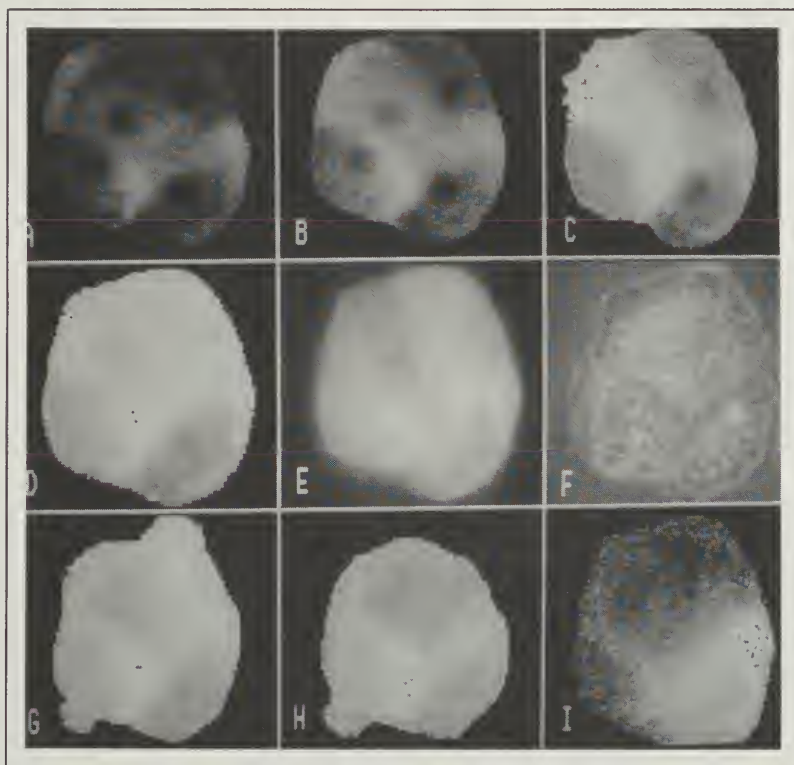


Figure 2. Changes in $[\text{Ca}^{2+}]_i$ as observed in a colony of four rat hepatocytes. Rat hepatocytes, isolated as described by Lemasters et al,¹¹ were cultured for two days. They were then loaded with Fura 2, a Ca^{2+} -sensitive fluorescent probe, treated with 1 mM KCN + 1 mM iodoacetate and examined by digital imaging fluorescence microscopy as described previously.⁸ Increases in $[\text{Ca}^{2+}]_i$ correlate with increasing intensity of the grey scale images that were generated by ratioing the fluorescent images acquired with 340 and 380 nm excitation wavelengths. Before treatment, $[\text{Ca}^{2+}]_i$ is about 100 nM, and nuclei are darker than the cytosol (Figure 2A); by 3 minutes, it is 2- to 3-fold higher in most cells (Figure 2B). Each cell then undergoes, in sequence, a large increase in $[\text{Ca}^{2+}]_i$, formation of cytoplasmic blebs, and, finally, cell death. At 7.1 minutes (Figure 2C), small blebs are apparent on the upper left cell. Figure 2D shows elevated $[\text{Ca}^{2+}]_i$ in three of the four cells. Figure 2E is one of the fluorescent image pairs (340 nm ex) used to generate the ratioed image in Figure 2D. Figure 2F is a phase microscopy image collected at 12 minutes showing two blebs on two cells. The blebs seen earlier in the upper left cell have disappeared. In Figure 2G, at 14 minutes, the two blebs are apparent in the ratioed image; at 18 minutes (Figure 2H), one bleb has disappeared and the two upper cells appear to be dead. By 20 minutes (Figure 2I), only the one cell (lower right) remains viable.

cleic acid) and protein, resulting in karyolysis.

Recovery phase

If blood flow is restored and the cells are reoxygenated during the reversible phase of ischemic injury, the recovery phase follows with a regenerative response in epithelial cells, such as in the liver or kidney, and recovery in nondividing cells, such as in the myocardium. Following restoration of blood flow, the cells begin to receive both oxygen and substrate. This usually leads to recovery; however, in some situations, it can also lead to further damage. In some systems, this additional injury has been attributed to the formation of active oxygen species through the xanthine-xanthine oxidase system.²

The recovery phase is associated with the rapid activation of a number of early immediate genes including *c-fos*, *c-jun*, and *c-myc*.⁴ The induction appears to involve Ca^{2+} -responsive elements, resulting in modulation of protein kinases, especially calmodulin kinase¹⁰ (Figure 3). Other protein kinases, such as protein kinase C, may also be activated, but

do not appear to be directly responsible for this early gene activation. This step is followed by activation of the gene regulator AP1, which can then initiate later stress or heat shock genes, including collagenase and metallothionein.

Conclusion

It is evident that clarification of the complex cellular events following anoxic or ischemic injury is developing through analysis at the cellular and molecular levels. The altered regulation of intracellular ions, especially $[Ca^{2+}]_i$, appears to be intimately involved in the initiation of injury, cell death, and recovery phases (in sublethally injured cells). Future studies should target the prevention and/or management of deregulation of $[Ca^{2+}]_i$ in this spectrum of disorders.

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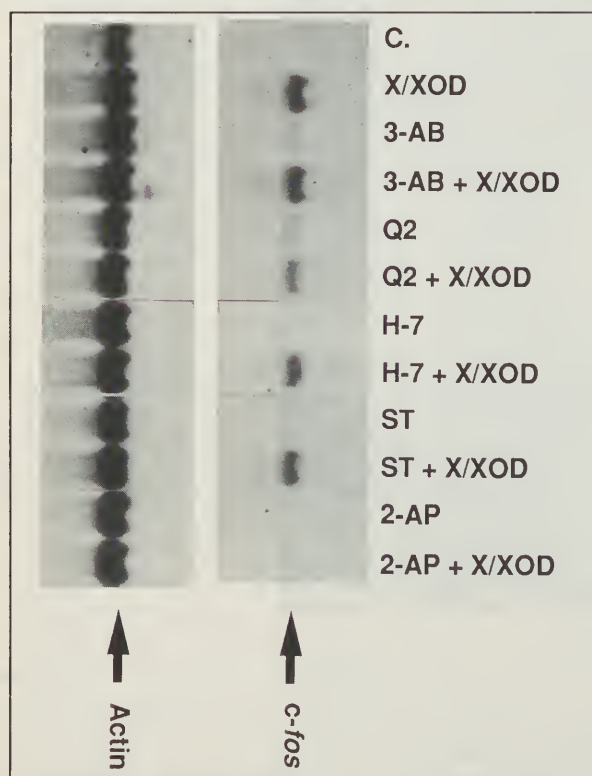


Figure 3. Modification of *c-fos* expression by X/XOD. Primary cultures of rat PTE treated with 100 μ M xanthine + 25 mU/ml xanthine oxidase for 30 minutes show a large increase in *c-fos* in comparison with untreated control cells (C). The mechanism of induction was studied by using the following: Quin 2/AM (Q2) (30 μ M) to buffer $[Ca^{2+}]_i$; protein kinase inhibitors, H7, 2-aminopurine (2-AP) and staurosporine (ST); and 3-aminobenzamide (3-AB), an inhibitor of poly ADP-ribosylation. Actin was used to normalize sample size. X/XOD-induced *c-fos* expression was inhibited by lowering $[Ca^{2+}]_i$ with Quin 2 and by inhibiting poly ADP ribosylation. [Reproduced with permission from Maki et al. *FASEB J* 1992; 6:919-24]

The ACCUPRIL Single-Agent CommitmentTM

Parke-Davis is confident that for many of your hypertensive patients ACCUPRIL will achieve the decrease in blood pressure you expect.

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‡ In some patients, the antihypertensive effect may diminish toward the end of the once-daily dosing interval. In such patients, an increase in dosage or twice-daily administration may be warranted.

ACCUPRIL is available in 10, 20, and 40 mg tablets. Usual initial starting dosage is 10 mg once daily.

ACCUPRIL is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Please see brief summary of prescribing information on following page.

Accupril® (Quinapril Hydrochloride Tablets)

USE IN PREGNANCY

When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, ACCUPRIL should be discontinued as soon as possible. See WARNINGS, Fetal/Neonatal Morbidity and Mortality.

Before prescribing, please see full prescribing information. A brief summary follows.

INDICATIONS AND USAGE

ACCUPRIL is indicated for the treatment of hypertension. It may be used alone or in combination with thiazide diuretics.

In using ACCUPRIL, consideration should be given to the fact that another angiotensin-converting enzyme (ACE) inhibitor, captopril, has caused agranulocytosis, particularly in patients with renal impairment or collagen vascular disease. Available data are insufficient to show that ACCUPRIL does not have a similar risk (see WARNINGS).

CONTRAINDICATIONS

ACCUPRIL is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

WARNINGS

Angioedema: Angioedema of the face, extremities, lips, tongue, glottis, and larynx has been reported in patients treated with ACE inhibitors and has been seen in 0.1% of patients receiving ACCUPRIL. Angioedema associated with laryngeal edema can be fatal. If laryngeal stridor or angioedema of the face, tongue, or glottis occurs, treatment with ACCUPRIL should be discontinued immediately, the patient treated in accordance with accepted medical care, and carefully observed until the swelling disappears. In instances where swelling is confined to the face and lips, the condition generally resolves without treatment; antihistamines may be useful in relieving symptoms. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, emergency therapy including, but not limited to, subcutaneous epinephrine solution 1:1000 (0.3 to 0.5 mL) should be promptly administered (see ADVERSE REACTIONS).**

Hypotension: Symptomatic hypotension was rarely seen in uncomplicated hypertensive patients treated with ACCUPRIL but, as with other ACE inhibitors, it is a possible consequence of therapy in salt/volume depleted patients, such as those previously treated with diuretics or dietary salt restriction or who are on dialysis (see PRECAUTIONS, DRUG INTERACTIONS, and ADVERSE REACTIONS). In controlled studies, syncope was observed in 0.4% of patients (N = 3203); this incidence was similar to that observed for captopril (1%) and enalapril (0.8%).

In patients with concomitant congestive heart failure, with or without associated renal insufficiency, ACE inhibitor therapy may cause excessive hypotension, which may be associated with oliguria or azotemia and, rarely, with acute renal failure and death. In such patients, ACCUPRIL therapy should be started at the recommended dose under close medical supervision. These patients should be followed closely for the first 2 weeks of treatment and whenever the dosage of antihypertensive medication is increased (see DOSAGE AND ADMINISTRATION).

If symptomatic hypotension occurs, the patient should be placed in the supine position and, if necessary, normal saline may be administered intravenously. A transient hypotensive response is not a contraindication to further doses; however, lower doses of ACCUPRIL or reduced concomitant diuretic therapy should be considered.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression rarely in patients with uncomplicated hypertension, but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease such as systemic lupus erythematosus or scleroderma. Agranulocytosis did occur during ACCUPRIL treatment in one patient with a history of neutropenia during previous captopril therapy. Available data from clinical trials of ACCUPRIL are insufficient to show that, in patients without prior reactions to other ACE inhibitors, ACCUPRIL does not cause agranulocytosis at similar rates. As with other ACE inhibitors, periodic monitoring of white blood cell counts in patients with collagen vascular disease and/or renal disease should be considered.

Fetal/Neonatal Morbidity and Mortality: ACE inhibitors can cause fetal and neonatal morbidity and death when administered to pregnant women. Several dozen cases have been reported in the world literature. When pregnancy is detected, ACE inhibitors should be discontinued as soon as possible.

The use of ACE inhibitors during the second and third trimesters of pregnancy has been associated with fetal and neonatal injury, including hypotension, neonatal skull hypoplasia, anuria, reversible or irreversible renal failure, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios in this setting has been associated with fetal limb contractures, craniofacial deformation, and hypoplastic lung development. Prematurity, intrauterine growth retardation, and patent ductus arteriosus have also been reported, although it is not clear whether these occurrences were due to the ACE inhibitor exposure.

These adverse effects do not appear to have resulted from intrauterine ACE inhibitor exposure that has been limited to the first trimester. Mothers whose embryos and fetuses are exposed to ACE inhibitors only during the first trimester should be so informed. Nonetheless, when patients become pregnant, physicians should make every effort to discontinue the use of ACCUPRIL as soon as possible.

Rarely (probably less often than once in every thousand pregnancies), no alternative to ACE inhibitors will be found. In these rare cases, the mothers should be apprised of the potential hazards to their fetuses, and serial ultrasound examinations should be performed to assess the intrauterine environment.

If oligohydramnios is observed, ACCUPRIL should be discontinued unless it is considered life-saving for the mother. Contraction stress testing (CST), a non-stress test (NST), or biophysical profiling (BPP) may be appropriate, depending upon the week of pregnancy. Patients and physicians should be aware, however, that oligohydramnios may not appear until after the fetus has sustained irreversible injury.

Infants with histories of *in utero* exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Exchange transfusion or dialysis may be required as a means of reversing hypotension and/or substituting for disordered renal function. Removal of ACCUPRIL, which crosses the placenta, from the neonatal circulation is not significantly accelerated by these means. No teratogenic effects of ACCUPRIL were seen in studies of pregnant rats and rabbits. On a mg/kg basis, the doses used were up to 180 times (in rats) and one time (in rabbits) the maximum recommended human dose.

PRECAUTIONS

General

Impaired renal function: As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including ACCUPRIL, may be associated with oliguria and/or progressive azotemia and rarely acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine have been observed in some patients following ACE inhibitor therapy. These increases were almost always reversible upon discontinuation of the ACE inhibitor and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some hypertensive patients with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when ACCUPRIL has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of any diuretic and/or ACCUPRIL may be required.

Evaluation of hypertensive patients should always include assessment of renal function (see DOSAGE AND ADMINISTRATION).

Hyperkalemia and potassium-sparing diuretics: In clinical trials, hyperkalemia (serum potassium ≥ 5.8 mmol/L) occurred in approximately 2% of patients receiving ACCUPRIL. In most cases, elevated serum potassium levels were isolated values which resolved despite continued therapy. Less than 0.1% of patients discontinued therapy due to hyperkalemia. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with ACCUPRIL (see PRECAUTIONS, Drug Interactions).

Cough: Cough has been reported with the use of ACE inhibitors. Characteristically, the cough is nonproductive, persistent, and resolves after discontinuation of therapy. ACE inhibitor-induced cough should be considered as part of the differential diagnosis of cough.

Surgery/anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, ACCUPRIL will block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients

Pregnancy: Female patients of childbearing age should be told about the consequences of second- and third-trimester exposure to ACE inhibitors, and they should also be told that these consequences do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. These patients should be asked to report pregnancies to their physicians as soon as possible.

Angioedema: Angioedema, including laryngeal edema, can occur with treatment with ACE inhibitors, especially following the first dose. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to stop taking the drug until they have consulted with their physician (see WARNINGS).

Symptomatic hypotension: Patients should be cautioned that lightheadedness can occur, especially during the first few days of ACCUPRIL therapy, and that it should be reported to a physician. If actual syncope occurs, patients should be told to not take the drug until they have consulted with their physician (see WARNINGS).

All patients should be cautioned that inadequate fluid intake or excessive perspiration, diarrhea, or vomiting can lead to an

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excessive fall in blood pressure because of reduction in fluid volume, with the same consequences of lightheadedness and possible syncope.

Patients planning to undergo any surgery and/or anesthesia should be told to inform their physician that they are taking an ACE inhibitor.

Hyperkalemia: Patients should be told not to use potassium supplements or salt substitutes containing potassium without consulting their physician (see PRECAUTIONS).

Neutropenia: Patients should be told to report promptly any indication of infection (eg, sore throat, fever) which could be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with ACCUPRIL is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions

Concomitant diuretic therapy: As with other ACE inhibitors, patients on diuretics, especially those on recently instituted diuretic therapy, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with ACCUPRIL. The possibility of hypotensive effects with ACCUPRIL may be minimized by either discontinuing the diuretic or cautiously increasing salt intake prior to initiation of treatment with ACCUPRIL. If it is not possible to discontinue the diuretic, the starting dose of quinapril should be reduced (see DOSAGE AND ADMINISTRATION).

Agents increasing serum potassium: Quinapril can attenuate potassium loss caused by thiazide diuretics and increase serum potassium when used alone. If concomitant therapy of ACCUPRIL with potassium-sparing diuretics (eg, spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes is indicated, they should be used with caution along with appropriate monitoring of serum potassium (see PRECAUTIONS).

Tetracycline and other drugs that interact with magnesium: Simultaneous administration of tetracycline with ACCUPRIL reduced the absorption of tetracycline by approximately 28% to 37%, possibly due to the high magnesium content in ACCUPRIL tablets. This interaction should be considered if coprescribing ACCUPRIL and tetracycline or other drugs that interact with magnesium.

Lithium: Increased serum lithium levels and symptoms of lithium toxicity have been reported in patients receiving concomitant lithium and ACE inhibitor therapy. These drugs should be co-administered with caution, and frequent monitoring of serum lithium levels is recommended. If a diuretic is also used, it may increase the risk of lithium toxicity.

Other agents: Drug interaction studies of ACCUPRIL with other agents showed:

- Multiple dose therapy with propranolol or cimetidine has no effect on the pharmacokinetics of single doses of ACCUPRIL.
- The anticoagulant effect of a single dose of warfarin (measured by prothrombin time) was not significantly changed by quinapril coadministration twice-daily.
- ACCUPRIL treatment did not affect the pharmacokinetics of digoxin.
- No pharmacokinetic interaction was observed when single doses of ACCUPRIL and hydrochlorothiazide were administered concomitantly.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Quinapril hydrochloride was not carcinogenic in mice or rats when given in doses up to 75 or 100 mg/kg/day (50 to 60 times the maximum human daily dose, respectively, on a mg/kg basis and 3.8 to 10 times the maximum human daily dose when based on a mg/m² basis) for 104 weeks. Female rats given the highest dose level had an increased incidence of mesenteric lymph node hemangiomas and skin/subcutaneous lipomas. Neither quinapril nor quinaprilat were mutagenic in the Ames bacterial assay with or without metabolic activation. Quinapril was also negative in the following genetic toxicology studies: *in vitro* mammalian cell point mutation, sister chromatid exchange in cultured mammalian cells, micronucleus test with mice, *in vitro* chromosome aberration with V79 cultured lung cells, and *in vivo* cytogenetic study with rat bone marrow. There were no adverse effects on fertility or reproduction in rats at doses up to 100 mg/kg/day (60 and 10 times the maximum daily human dose when based on mg/kg and mg/m², respectively).

Pregnancy

Pregnancy Categories C (first trimester) and D (second and third trimesters): See WARNINGS, Fetal/Neonatal Morbidity and Mortality

Nursing Mothers

It is not known if quinapril or its metabolites are secreted in human milk. Quinapril is secreted to a limited extent, however, in human milk, caution should be exercised when ACCUPRIL is given to a nursing mother.

Geriatric Use

Elderly patients exhibited increased area under the plasma concentration time curve (AUC) and peak levels for quinaprilat compared to values observed in younger patients; this appeared to relate to decreased renal function rather than to age itself. In controlled and uncontrolled studies of ACCUPRIL where 918 (21%) patients were 65 years and older, no overall differences in effectiveness or safety were observed between older and younger patients. However, greater sensitivity of some older individual patients cannot be ruled out.

Pediatric Use

The safety and effectiveness of ACCUPRIL in children have not been established.

ADVERSE REACTIONS

ACCUPRIL has been evaluated for safety in 4960 subjects and patients. Of these, 3203 patients, including 655 elderly patients, participated in controlled clinical trials. ACCUPRIL has been evaluated for long-term safety in over 1400 patients treated for 1 year or more.

Adverse experiences were usually mild and transient.

Discontinuation of therapy because of adverse events was required in 4.7% of patients treated with ACCUPRIL in placebo-controlled hypertension trials.

Adverse experiences probably or possibly related to therapy or of unknown relationship to therapy occurring in 1% or more of the 1563 patients in placebo-controlled hypertension trials who were treated with ACCUPRIL are shown below.

Adverse Events in Placebo-Controlled Trials

	ACCUPRIL (N = 1563) Incidence (Discontinuation)	Placebo (N = 579) Incidence (Discontinuation)
Headache	5.6 (0.7)	10.8 (0.7)
Dizziness	3.9 (0.8)	2.6 (0.2)
Fatigue	2.6 (0.3)	1.0
Coughing	2.0 (0.5)	0.0
Nausea/Vomiting	1.4 (0.3)	1.9 (0.2)
Abdominal Pain	1.0 (0.2)	0.7

See PRECAUTIONS, Cough.

Clinical adverse experiences probably or possibly related, or of uncertain relationship to therapy, occurring in 0.5% to 1.0% (except as noted) of the patients treated with ACCUPRIL (with or without concomitant diuretic) in controlled or uncontrolled trials (N = 4397) and less frequent, clinically significant events seen in clinical trials or post-marketing experience (the rarer events are in italics) include (listed by body system):

General: back pain, malaise

Cardiovascular: palpitation, vasodilation, tachycardia, heart failure, hyperkalemia, myocardial infarction, cerebrovascular accident, hypertensive crisis, angina pectoris, orthostatic hypotension, cardiac rhythm disturbances

Gastrointestinal: dry mouth or throat, constipation, gastrointestinal hemorrhage, pancreatitis, abnormal liver function tests

Nervous/Psychiatric: somnolence, vertigo, syncope, nervousness, depression

Integumentary: increased sweating, pruritus, exfoliative dermatitis, photosensitivity reaction

Urogenital: acute renal failure

Other: amblyopia, pharyngitis, sinusitis, bronchitis, agranulocytosis, thrombocytopenia

Fetal/Neonatal Morbidity and Mortality

See WARNINGS, Fetal/Neonatal Morbidity and Mortality.

Angioedema: Angioedema has been reported in patients receiving ACCUPRIL (0.1%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with ACCUPRIL should be discontinued and appropriate therapy instituted immediately (see WARNINGS).

Clinical Laboratory Test Findings

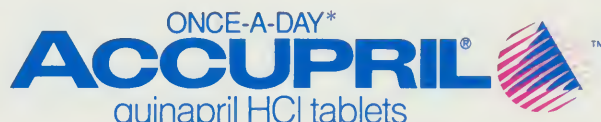
Hematology: (See WARNINGS)

Hyperkalemia: (See PRECAUTIONS)

Creatinine and blood urea nitrogen: Increases (71.25 times the upper limit of normal) in serum creatinine and blood urea nitrogen were observed in 2% and 2%, respectively, of patients treated with ACCUPRIL alone. Increases are more likely to occur in patients receiving concomitant diuretic therapy than in those on ACCUPRIL alone. These increases often remit on continued therapy.

*In some patients, the antihypertensive effect may diminish toward the end of the once-daily dosing interval. In such patients, an increase in dosage or twice-daily administration may be warranted.

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Human injuries following jellyfish stings

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There are approximately 500,000 jellyfish stings every year in the Chesapeake Bay. Dr. Burnett describes the mechanism of jellyfish stings, venom components, types of reactions, diagnosis, and therapy.

Noxious jellyfish occur in both brackish or salt water bodies. These animals possess tentacles with intracytoplasmic organelles (nematocysts) containing coiled toxin-coated threads. These organelles are located in the outermost epithelial layer when in the "fire ready" position and can be contracted by a fibrillar network to an unexposed position when the animal apparently is not feeding or is not endangered. Some recent evidence indicates that the wiggling behavior of nearby prey may be an important factor in controlling nematocyst release.¹ Other evidence demonstrates that the thread (nema) everts when chemically triggered. Since it is propelled with a force of approximately two to five pounds per square inch, the thread with its viscous venom penetrates to the nerve and vascular rich dermis. Most jellyfish contain several nematocyst types clustered in moveable groups or "batteries" on the tentacle's outer epithelial layer. Some of the organelles adhere to prey, but others possess different injurious toxins for defense or predation.

The commonest toxic jellyfish in Maryland is the sea nettle (*Chrysaora quinquecirrha*)—the summer Chesapeake Bay jellyfish (Figure 1). Another local species is *Cyanea capillata* (lion's mane), an animal made famous by a Sherlock Holmes detective story. This coelenterate is found in the bay during the winter and spring and in the ocean, along with the sea nettle, in the summer. The presence of *Physalia physalis* (Portuguese man-of-war) is very unusual in Maryland waters.

The rate of absorption of jellyfish venom in man varies with local muscular action (muscle pump) and the content or concentration of the venom. The potency of the venom to produce human cutaneous pain, mouse lethality, hemolysis, or dermonecrosis is species dependent. In all of the above parameters, the Portuguese man-of-war venom is considerably more active than that of the sea nettle. However, sea nettle venom has been studied more because it is collected from the most abundant, predictably occurring, venomous marine animal in the world.

Jellyfish stings are common with an estimated 500,000 annual envenomizations occurring in the Chesapeake Bay and 60,000 to 200,000 in



Figure 1. Adult sea nettle medusa (*Chrysaora quinquecirrha*). Reprinted with permission from *Archives of Dermatology* 1968; 98:587-9. Copyright 1968, American Medical Association.

Florida. Venom injury in humans occurs either by toxic or irritant reactions or by immunological or allergic mechanisms.² Immunological reactions appear to be humoral (B-cell) and cell-mediated (T-cell) phenomena. Toxic reactions occur in all individuals, follow every exposure, and are directly dose related. Immunological reactions, on the other hand, require prior exposure to the venom, do not occur in all people, and are not always dose related. It should be emphasized that both the allergic and toxic

reactions can occur concurrently, be serious, be delayed, and alter states of consciousness. Allergic reactions to venoms are not necessarily progressively serious with each exposure and can follow contact with venom from cross-reacting animals.

Venom components

Jellyfish venoms are polypeptide mixtures with many enzymatic actions.^{3,4} The sea nettle has two types of tentacles: peripheral lace-like fishing tentacles and central mesenteric tentacles. Although the nematocyst component of these structures is very similar, the molecular weight of their venoms differs. The active nematocyst components weighing 100 to 190 kilodaltons are similar in the two tentacles.^{5,6} Crude nematocyst venom is viscous and contains a collagenase, a hyaluronidase, nucleases, proteases and phosphatases.^{3,4} Histamine, histamine releasers, and serotonin-like and kinin-like products are also present.^{3,4,7} The dosage of venom delivered to the victim is impossible to calculate since the number of nematocysts available in the fire-ready position and the spacing of these structures in batteries on the tentacle are variable.⁸ Measuring the length of the tentacle-victim's skin contact can be a helpful but inexact finding.⁹

Fatal reactions

Mouse lethality occurs by injury to any of three different organ systems in a dose-dependent manner. Large doses of

sea nettle venom produce a cardiotoxic reaction on the myocardium, Purkinje's fibers, and the coronary vasculature giving varying degrees of heart block and ventricular standstill within seconds to a few hours. Intermediate venom doses depress the respiratory center within twenty-four hours. Finally, smaller doses cause death from renal damage and hyperkalemia after one to two days.^{3,4} The use of verapamil can prevent cardiotoxic death in animals, yet the animals will succumb in several hours to respiratory depression.¹⁰ Verapamil can instantly reverse the cardiac arrhythmia caused by jellyfish venom.¹¹

A similar death occurs in man following jellyfish stinging.¹² Several fatalities occur annually after box-jellyfish envenomizations in the Indo-Pacific region and, in 1988, two deaths on the American Atlantic coast following Portuguese man-of-war envenomization were recorded.^{13,14} These deaths were thought to be due to a calcium and/or sodium ionic transfer defect.^{3,5,10}

Anaphylaxis, the most serious allergic reaction, rarely occurs from jellyfish stings.¹⁵ Clinical differentiation of a venom-induced cardiorespiratory toxic death from anaphylaxis can be difficult since, in either instance, the patients have cardiovascular collapse several minutes after the tentacular contact.

Systemic reactions

Systemic reactions to jellyfish envenomizations include nausea, vomiting, muscle cramps, diarrhea, dizziness, unfocused vision, diaphoresis, fainting, coma, convulsions, muscular spasms, and respiratory acidosis (if the sting is on the thorax).^{16,17} An Irukandji reaction occurs after envenomization from several carybdeid jellyfish in northeastern Australia. While no American cases have yet been reported, we suspect that rare unrecognized cases occur. This reaction follows a minor painful sting. After five to forty minutes, a boring pain begins in the lower trunk spreading quickly to the chest and thigh. Alternating tightness and waves of excruciatingly severe muscle pain intensify over a few minutes. There are increased sighing respirations, restlessness, tremor, anxiety, headache, localized or general piloerection, sweating, pallor, cyanosis, oliguria, tachycardia, nausea, hypertension, pulmonary edema with left ventricular dilatation, and feelings of imminent death lasting one to two days.¹⁸ The symptomatology can resemble a catecholamine crisis, and some symptoms are reversed with phentolamine therapy.

Two years ago, a healthy male, who was envenomed on the forearm in Florida, suffered from local pain and profound vomiting over a period of several hours. His liver enzymes (SGOT—serum glutamic oxaloacetic transaminase, SGPT—serum glutamic pyruvic transaminase) were elevated for more than sixteen days, and he had elevated equal titers of serum IgG (immunoglobulin G) to *Physalia* and *Chiropsalmus* venoms.

Local reactions

The local reactions produced by jellyfish stings are painful, linear, erythematous, urticarial lesions wherever tentacular

contact has occurred (**Figure 2**). Corneal lesions are especially painful.¹⁹ Cutaneous pain occurs almost instantly, reaching an apex within a few minutes and persisting for several hours. The eruptions may be bullous or dramatically edematous, may be delayed for several hours, may persist for several months, or may recur without further stings.^{16,20-23} The recurrent eruptions are similar in severity but are pruritic, not painful. The recurrent eruptions appear at four- and thirty-day intervals and last up to twenty-eight days. The number of recurrent attacks can be as many as four, and some of the episodes of eruptions can be accompanied by diarrhea. Immediate erythematous, edematous, urticarial eruptions can appear distant from the site of the sting.²⁴ Two patients have been reported with papular urticarial lesions located on the body away from the envenomization site.¹⁶ Another two patients with exaggerated localized reactions (angioedema) have been recognized; only one of these individuals developed anaphylaxis with subsequent stings.¹⁵ Cases of unusual eruptions following jellyfish envenomizations have occurred in oceanic waters of the eastern United States. None have followed Chesapeake Bay stings, although one patient could have been "primed" there.²³

Examination of skin biopsies from patients with local jellyfish stings, recurrent eruptions, or persistent lesions reveals an inflammatory picture. Specimens from patients with ordinary stings show a chronic lymphocytic infiltrate that is patchy



Figure 2. A 45-hour-old linear vesicular erythematous eruption that appeared at the site of a previous sting inflicted two weeks previously.

and located primarily around the vessels in the upper dermis. The dermal lymphocytes are both helper (T₄-stain) and suppressor (T₈-stain), with the former being more abundant. Examination of patients with recurrent lesions showed a deeper dermal lymphocytic infiltrate. There is no deposition of complement or IgG at the dermal epidermal junction or around the vessels. The pathologic finding observed on biopsied specimens of persistent lesions is a granuloma.²² Contact urticaria due to jellyfish tentacles has also been reported in humans.²⁵

Other reactions

Post-episode dermatitis. Local stings may be followed by recurrent herpes simplex or granuloma annulare at the site of the wound.¹⁶

Long-term reactions. Chronic reactions at the wound include hyperpigmentation (postinflammatory or tattooing from the jellyfish), keloids, contractions, fat atrophy, and vasospasm with gangrene.^{26,27} Two cases of temporary mononeuritis multiplex involving a nerve near, but not in, the stung area have been reported subsequent to coelenterate envenomizations.^{28,29} Patients with autonomic nerve paralysis with a distended abdomen, urinary bladder dilatation, impotency, an inability to produce tears or urinate,³⁰ diplopia, and ataxia¹⁶ have been reported. The six cases of vasospasm, contracture, and gangrene occurred in the Indo-Pacific region, and most of these individuals still have significant disability.

Reaction from jellyfish ingestion. In countries where dry jellyfish are served as food, postprandial urticaria and gastrointestinal symptoms or contact dermatitis have resulted.²⁵

Systemic pathology. The skin is not the only organ showing pathological changes. Centrilobular hepatic necrosis and proximal renal tubular damage have been detected in experimental animals after sublethal injections.³¹

Sexual susceptibility. Females have a predilection for some jellyfish envenomization syndromes. Although more men than women swim, five of the six cases of vasospasm with gangrene and 80 percent of the recurrent eruptions following single envenomizations from jellyfish stings have been females. Most of the patients with persistent cutaneous lesions and the solitary cases of fat atrophy and of granuloma annulare were females. Both cases of papular urticaria and the patient who had a distant eruption following a jellyfish sting were women. Only time will tell whether this trend persists.

Jellyfish-sting reactions in abnormal or medicated patients. Very little information is available about the reaction of abnormal or medicated patients stung by jellyfish. Pregnant women or patients receiving weekly ragweed immunization medication appear to respond normally.³² One woman taking 60 mg prednisone noticed that the linear eruption following tentacle contact was pain-free and delayed two days. She, however, suffered from four recurrent episodes related to that sting.²³

Immunology

Jellyfish venoms can affect both humoral and cell-mediated immunity in man. Envenomed swimmers develop IgM

and IgG antibodies that may persist for many years.³³ Lymphokine release from circulating peripheral blood leukocytes, leukocyte stimulation, or suppression of natural killer cell enhancement have been demonstrated in convalescing patients, especially those with recurring lesion.^{23,34,35} There is cross reactivity of antibody production and increased T-cell activity induced by venoms of different jellyfish. Systemic immunosuppression in a human volunteer was detected after injecting large intradermal doses of venom.³⁶ The interplay of this immunosuppression with that received from ultraviolet light at the beach is not known.

Diagnosis

Identification of jellyfish envenomization is often obvious after examining the patient and obtaining a history. Diagnosis of the offending animal is helpful and can be assumed by having knowledge of the usual fauna at the place and time of the envenomization. The type of species can be confirmed by recognizing nematocysts on biopsied skin or on stratum corneum scrapings. Clinical corroboration of a sting can be obtained by rubbing one's hands on the area and then having the examiner touch his or her own skin to detect secondary stings. Serologic tests can be performed on specific jellyfish exposure.³¹ Cross-reacting antibodies have been reported after envenomizations, yet venom of the offender appears to elicit the highest titer. T-cell studies have been performed after jellyfish envenomization but are experimental.³⁴

Therapy

Anaphylaxis from jellyfish envenomizations should be treated in the customary manner by maintaining the airway and cardiovascular system. The insertion of an intravenous life-line and administration of epinephrine is essential. Treatment of a serious cardiotoxic venom reaction includes similar measures except that intravenous verapamil should be considered.¹⁰ Nifedipine is not as effective as verapamil, and diltiazem is nonefficacious. The only effective specific antisera available are directed toward Australian box-jellyfish envenomizations. This preparation has been helpful for stings by those species and are potentiated by verapamil.³⁷ All patients should be reassured and placed at rest. The injured part is splinted to reduce the pump action of nearby muscles to localize the venom. Application of ice cubes or counterirri-

tants elsewhere on the body can be helpful for pain relief. Analgesia must be obtained systemically since no topical preparation rapidly penetrates the epidermis. Heat as therapy in jellyfish envenomization is contraindicated since it might increase the systemic uptake of venom.²⁹

No certain method of deactivating unfired nematocysts within tentacle fragments on the victim's skin has been developed. However, previous studies have indicated that the use of preparations such as vinegar or baking soda pastes may be partially beneficial.^{38,39} Vinegar should be employed for man-of-war stings, and baking soda slurries for those induced by the nettle or the lion's mane jellyfish. These preparations should not be administered prior to maintaining life support systems. Once the patient is stable and the tentacle fragments inactivated, manual removal of any adherent tissue can follow.

Hydroquinone bleaches are used for hyperpigmentation, and keloids are treated in the standard manner. The use of nonsteroidal analgesics in cases of prolonged, persistent reactions or recurrent episodes has not been experimentally proven. Experimentally, piripost (a leukotriene inhibitor) prevented some of the capillary damage produced by the venom.⁴⁰

Mechanical barriers to jellyfish at the beach have been effective in Australia where specialized structures have been designed. Formfitting pajama-like garments are popular with windsurfers in that country to protect them against jellyfish stings. Topical barrier ointments have been tried but are not cosmetically attractive and do not protect the eyes. Observers posted to supervise swimming in the Chesapeake Bay are ineffective because of the dark color of the plankton-rich water.

Conclusions

Noxious jellyfish injure man in a variety of ways. Newer syndromes have been uncovered as investigators have probed the cause of the pathogenesis of jellyfish stings. Death results from toxic or immunological reactions in man. Unusual cutaneous eruptions and systemic effects of the envenomization have been reported. These reactions appear to be species specific, and future therapy will vary according to the envenomizing animal and the pathogenesis of the disorder.

Clinical syndromes produced by jellyfish envenomization

Local reactions

- Toxin-induced to skin, mucosa, and cornea
- Exaggerated local reaction (angioedema)
- Recurrent reactions up to four episodes
- Delayed persistent reactions up to several months
- Distant site reactions
- Local lymphadenopathy

Long-term reactions

- Keloids
- Pigmentation
- Fat atrophy
- Contractions
- Gangrene
- Vascular spasm
- Mononeuritis
- Autonomic nerve paralysis
- Ataxia
- Increased intraocular pressure

Post-episode dermatitis

- Herpes simplex
- Granuloma annulare

Reactions from jellyfish ingestion

- Gastrointestinal symptoms
- Urticaria

Systemic reactions

- Toxin-induced
- Irukandji reaction
- Respiratory acidosis
- Blurred vision
- Monarticular arthralgia and reactive arthritis
- Pronounced vomiting

Fatal reactions

- Toxin-induced
- Immediate cardiac arrest
- Rapid respiratory arrest
- Delayed renal failure
- Anaphylaxis

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The supportive care unit— Inpatient geriatric rehabilitation: Preliminary data

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Hospital availability of a comprehensive geriatric rehabilitation service, such as the Supportive Care Unit at the University of Maryland, can help achieve the goals of preserving present levels of function, avoiding losses of function, and restoring independence in the frail elderly.

There is compelling evidence that disability increases with age and that multiple impairments increase significantly after age 75. Estimates of the noninstitutionalized elderly population with limitations in personal and instrumental activities of daily living (ADLs and IADLs) range from 12 percent with ADL limitations lasting more than three months to 25.5 percent or 6.7 million persons with any ADL or IADL limitation.¹ This proportion rises from 19 percent among persons aged 65–74, to 31 percent among persons 75–84 years, and to 55 percent among those over 85 years. Thus, there is a great need to preserve an independent lifestyle for the elderly person to the maximal extent possible. Older persons' needs created by ill health and disability may strain care providers to the point that providers may no longer offer to continue support. Furthermore, there is evidence suggesting that the major determinants of nursing home admission are advanced age, dependency in ADLs and IADLs, use of an aid for ambulation, and impaired mental status.^{2,3}

Loss of functional independence is a common pathway for many disorders in older persons, especially those hospitalized for an acute illness. Imposed bed rest further complicates and exacerbates the decline in functional status.⁴ Older people frequently incur major functional setbacks stemming from in-hospital treatment and immobilization with resultant deconditioning. The cardiovascular and musculoskeletal systems are most adversely affected. It is estimated that daily losses of 1 to 1.5 percent of muscle strength occur with bed rest. This is a decline of 10 percent in strength after one week for an older person who is at threshold strength for climbing stairs or getting to the bathroom, and this decline in strength may make the difference between dependence and independence.⁵

Rehabilitation is a continuing comprehensive team effort to restore an individual to his/her former functioning and environmental status or to

maintain or maximize remaining function. The goal is to limit functional losses and direct energies toward maximizing resources such that a patient can be returned to the least restrictive discharge environment possible. Even very elderly individuals, including those with chronic disease, can participate in exercise programs and show improvement in cardiovascular function, fitness, strength, and flexibility.⁶⁻⁸

The supportive care unit

Since 1987, the Department of Family Medicine, Division of Geriatric Medicine, has managed a model geriatric rehabilitation program, specifically dedicated to the rehabilitation of frail elderly individuals. It is a continuation of a Robert Wood Johnson-sponsored demonstration project designed to act as a bridge between acute and long-term care for elderly hospitalized patients.⁹ The program is unique in that, while it is housed in an acute care hospital, it offers step-down care at a lower per diem cost, yet patients receive the intensity of care comparable to acute hospital ward patients. The beds are licensed under the long-term care system at a "chronic level of care" and are used to house for rehabilitation, patients who have had an acute medical or surgical event, with the aim of discharge to the community. The categories of patients that are appropriate for this chronic level of care include those who usually require more frequent attendance of a geriatrician than is available in skilled nursing homes. These patients require regular examinations and judgment decisions from a physician and also require continued skilled nursing services at a level ordinarily not available in a skilled nursing home. Potential candidates are referred from hospitals, home health care agencies, private physicians, and nursing homes. Each candidate is evaluated by a liaison rehabilitation nurse who visits the patient and assesses the medical reason for rehabilitation and the patient's physical condition, medical stability, mental status, motivation, family support, present functional status, and estimated potential for rehabilitative/restorative gains.

The unit is run using a medical model and, upon admission, the patient is evaluated by a multidisciplinary team including physician, nurse, social worker, physical therapist, occupational therapist, and speech/language pathologist when indicated. Residents from the Department of Family Medicine are attached to the unit during their compulsory second-year rotation in geriatrics. Students from all disciplines may choose to spend clinical attachments here also.

Specific treatment plans for functional improvement are established and an estimated length of stay is agreed on. The discharge plan is tailored to meet the patient's needs and takes into consideration the willingness and ability of the patient's family (or other caregiver) to provide support and care if needed. An intensive program of therapy sessions is instituted. Progress is constantly monitored by the interdisciplinary team. On discharge, the Supportive Care Unit links the patient to community resources including in-home aides, skilled nursing assistance, companion services, home health equipment, and other specialized services. Follow-up medi-

cal care is usually through the patient's primary physician. If return home is no longer practical, then alternatives are arranged.

Results

In the unit's three years of existence, over 500 patients have been admitted. The mean age was 77.3 years (± 8.96), and the oldest patient was 101 years old. The majority of patients were female, white, and widowed (Table 1). Women were statistically more likely to be widowed than their male counterparts (74 percent vs 34 percent, $p < .001$). At the time of admission, nearly all patients either lived alone or with family or relatives.

The major reason for admission was rehabilitation after an acute orthopaedic procedure (68.7 percent). This included patients admitted for rehabilitation after fracture repairs (primarily hip) and after total hip and knee replacements. Other diagnoses included stroke (13.2 percent), amputation (4.0 percent), rehabilitation after a cardiac event (2.6 percent), or debilitating arthritis (2.9 percent). Forty patients (8 percent) were admitted for rehabilitation after prolonged hospital stays for acute medical events that resulted in severe functional deconditioning. This group also included patients with other neurological problems such as multiple sclerosis and Guillain-Barré syndrome. The mean length of stay for all patients was 22 days ± 14 , with longer stays for patients admitted for rehabilitation after a stroke or because of deconditioning than for those admitted for rehabilitation after an orthopaedic pro-

Table 1. Demographic characteristics of patients

		N	Percent
Sex	Female	422	77.3
	Male	124	22.7*
Age	77.3 \pm 8.96 yrs (Range 38.9–101)		
Race	White	431	78.9
	African-American	111	20.3
	Asian	2	0.4
	Other	2	0.4
Marital status	Widowed	353	64.7
	Married	121	22.2
	Single	44	8.1
	Divorced	23	4.2
	Separated	5	0.9
Living status	Family/relative	274	50.4
	Alone	242	44.2
	Attendants	13	2.4
	Friends	8	1.5
	Other	7	1.3
Discharge living arrangement	Family/relatives	293	53.6
	Alone	155	28.9
	Other	56	10.4
	Attendants	27	5.0
	Friends	5	0.9
Major diagnoses	Orthopaedic	376	68.7
	Cardiovascular accident	72	13.2
	Other	47	8.6
	Amputation	22	4.0
	Arthritis	16	2.9
	Cardiac	14	2.6

cedure or amputation (30 days \pm 16 vs 20 days \pm 12, $p < 0.05$). On admission, patients had evidence of moderate to severe functional impairment (Table 2). Patients admitted for rehabilitation after a stroke were the most functionally impaired (mean Barthel score: 41 ± 15.6) and were significantly more impaired than the orthopaedic (58 ± 10), deconditioned (53 ± 17), cardiac (52 ± 12), and arthritic (51 ± 13) patients. The mean Barthel¹⁰ measure of functional status improved by close to 30 points by the time of discharge (55.7 ± 13.6 to 82.4 ± 18.3 , $p < 0.05$).

Eighty-five percent of patients admitted to the unit were discharged home, with the majority of these returning to live with family or relatives. Those patients with more severe functional issues on admission had longer lengths of stay ($r = 0.26$, $p < 0.05$). Patients not discharged home were more likely ($p < 0.05$) to have been admitted for rehabilitation after a stroke (71 percent home) or cardiac event (64 percent home). More than 80 percent of patients in all other diagnostic groups were discharged home. The greatest improvement in functional status was seen in the orthopaedic patients (mean discharge Barthel score: 87 ± 13), followed by patients with amputations (85 ± 19), deconditioned patients (80 ± 19), arthritic patients (79 ± 22), cardiac patients (77 ± 22), and stroke patients (61 ± 23). Follow-up data collection is ongoing but the majority of patients (80 percent) continued to be at home at each follow-up interval (Table 2). Approximately 5 to 10 percent of patients are admitted to skilled nursing facilities at each interval of follow-up, and 4 to 7 percent of these patients have expired. The mean Barthel score remains unchanged over twenty-four months of follow-up.

Table 2. Patient outcomes after admission to supportive care						
	Admission (N = 546)	Discharge (N = 541)	2-Month (N = 437)	6-Month (N = 322)	12-Month (N = 216)	24-Month (N = 33)
Barthel	55.7 \pm 13.6	82.4 \pm 18.3	83.2 \pm 20.2	83.2 \pm 20.1	83.5 \pm 19.7	82.3 \pm 19.6
Discharge location						
Home		468 (86.5%)	356 (81.5%)	252 (78.3%)	162 (75%)	26 (78.8%)
Skilled nursing		28 (5.2%)	27 (6.2%)	29 (9.0%)	20 (9.3%)	3 (9.1%)
Board and care		11 (2%)	7 (1.6%)	6 (1.9%)	6 (2.8%)	
Intermediate care		4 (0.7%)	4 (0.9%)	2 (0.6%)	3 (1.4%)	1 (3%)
Expired		4 (0.7%)	18 (4.1%)	20 (6.2%)	16 (7.4%)	2 (6.1%)
Hospitalized		20 (3.7%)	21 (4.8%)	7 (2.1%)	4 (1.8%)	
Other		6 (1.1%)	4 (0.9%)	6 (1.9%)	5 (2.3%)	1 (3%)

Discussion

These preliminary data show that the Supportive Care Unit has been highly successful. Over 85 percent of the frail elderly people admitted had significantly improved on discharge to homes. The majority of these patients maintained their level of functional improvement over a two-year follow-up interval. Eighty percent of the patients who are still living were in their own homes at each follow-up interval up to two years after discharge. These numbers are better than those that have been previously reported in prospective studies of elderly patients. In a study of patients followed for a year after rehabilitation following stroke, 49 percent returned home and 77 percent of survivors were still at home a year later.¹¹ In

another study following patients with fractures of the proximal femur, 69 percent of the treatment group were living at home at one year and 6 percent were in institutions.¹² A study of frail elderly patients admitted to a geriatric rehabilitation unit in a community hospital found that 67 percent were living in the community six months after discharge.¹³ These descriptive data are further supported by two randomized studies^{14,15} of the effectiveness of geriatric rehabilitative care. Both studies concluded that the treatment of selected elderly patients in a specialized geriatric rehabilitation unit improves function, reduces the risk of nursing home placement, and may reduce mortality. These preliminary data also support evidence showing that age itself, when controlled for co-morbidity and extensive neurologic impairment, is not a clinically relevant factor in stroke rehabilitation outcome.¹⁶

The need for geriatric rehabilitation units such as the Supportive Care Unit is becoming more critical since the introduction of the Medicare Prospective Payment System (PPS) and increasing costs under DRGs (diagnostic-related groups). Such changes have resulted in more early discharges of post hip surgery patients to nursing homes, with hospital stays decreasing from 21.9 days to 12.6 days.^{17,18} A disquieting effect of this early discharge policy has been a dramatic increase in patients remaining indefinitely in community nursing homes. One third of all patients studied who were alive at one year resided in a nursing home compared with only 9 percent prior to PPS.

A crucial question for those committed to individualized rehabilitative care for older patients will be: Have we done enough—soon enough—to preserve an autonomous inde-

pendent lifestyle for those who could benefit. A goal for the future should be that every general hospital should have access to a comprehensive geriatric rehabilitation service at both the acute and extended care levels.¹⁹ Perhaps, as

suggested by Dr. Franklin Williams and others,²⁰ older patients admitted to the hospital for acute services should automatically have a geriatric rehabilitation team consultation. Then, every effort can be directed at preserving present levels of function, avoiding losses of function, and restoring independence. Perhaps then, the individuality and autonomy of older persons will be respected and preserved.¹⁹

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Unusual articular manifestations in chronic renal disease

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We report thirteen patients with chronic renal disease who demonstrate one or more sites of arthropathy including three with combined spine and shoulder changes.

Various skeletal abnormalities have been described in patients with chronic renal failure on long-term hemodialysis. These include renal osteodystrophy (secondary hyperparathyroidism, osteomalacia, and osteosclerosis), osteoporosis, soft tissue calcifications, osteonecrosis, and crystal-induced arthritis.^{1,2} These patients are also at increased risk for the development of pyogenic infections of bones and joints.³

Two additional types of arthropathy have been described in these patients. The first is a destructive, rapidly progressive spondyloarthropathy resembling an infectious spondylitis.³⁻⁸ The second consists of erosions at various sites in the appendicular skeleton, with a predilection for the articulations of the hands and wrists, shoulders, and knees.^{2,9-11}

Despite an increasing number of reports describing these arthropathies, only one illustrates a combination of spondyloarthropathy and arthropathy of the hands,¹² and none describe simultaneous spine and shoulder involvement. We report thirteen patients with chronic renal disease who demonstrate one or more sites of arthropathy including three with combined spine and shoulder changes.

Materials and methods

The thirteen patients consisted of seven males and six females ranging in age from 15 to 68 years (mean: 52 years). The patients had been on dialysis from 1 to 14 years (mean: 7 years) by the time that articular abnormalities were identified.

Available radiographs of the hands, wrists, shoulders, and spine were reviewed retrospectively for erosive changes not typically seen in the setting of chronic renal failure. No patients were found to be rheumatoid factor positive or to exhibit clinical and laboratory stigmata of a seronegative arthropathy. Percutaneous or open-needle biopsy was performed on



Figure 1. Shoulder arthropathy. Erosions are present involving the humeral head, greater tuberosity, and glenoid. More familiar erosion of the distal clavicle is also present.



Figure 2. Shoulder arthropathy. There is erosion of the glenoid articular surface with destruction of much of the humeral head resembling neuropathic arthropathy.

all five cases of spondyloarthropathy to exclude superimposed infection.

Results

Five of the thirteen patients demonstrated glenohumeral joint arthropathy with articular erosions involving the humeral head in all five, the greater tuberosity in three, and the glenoid in four (**Figure 1**). Two patients developed a destructive arthropathy resembling neuropathic disease (**Figure 2**).

Seven of the thirteen patients demonstrated an erosive arthropathy involving the hands, wrists, or both. Erosions were present in the distal interphalangeal joints in six patients, the proximal interphalangeal joints in three, the metacarpophalangeal joints in six, and intercarpal joints in four. Three patients developed a destructive arthropathy involving at least one joint (**Figure 3**).

Five of the thirteen patients demonstrated a destructive spondyloarthropathy characterized by disc destruction, endplate erosion, and vertebral body collapse (**Figure 4**). One case consisted solely of an erosive arthropathy involving a cervical facet joint. There were two cases in each of the cervical, thoracic, and lumbar regions.

In three of the thirteen patients, spondyloarthropathy was present concurrent with arthropathy of the shoulder (**Figures 2 and 4**). One of these patients also demonstrated arthropathy in the hands and wrists.

Discussion

The association of chronic renal failure with skeletal disease has been known for over a century, yet the entity of destructive noninfectious spondyloarthropathy has only recently been documented.³⁻⁸ Multiple factors have been considered in its pathogenesis including hyperparathyroidism¹³ and deposition of iron,¹⁴ aluminum,¹⁵ calcium oxalate,¹⁶ hydroxyapatite,^{2,5} calcium pyrophosphate,³ or amyloid associated with beta-2 microglobulin.¹⁷⁻²⁰

Radiographic changes consist of a rapidly progressive spondyloarthropathy with marked reduction of the disc space, destruction and sclerosis of the adjacent endplates, and absence of osteophytosis and paravertebral soft tissue mass. Clinically, these patients present with local pain. Rarely, there can be associated compromise of the spinal canal. No evidence of infection is found on biopsy, and radiologic deterioration continues in spite of antibiotic therapy.

A second distinct entity consists of an erosive arthropathy involving the appendicular skeleton, often mimicking rheumatoid arthritis.^{11,21} The hands and wrists tend to have the greatest frequency of involvement.^{2,22} Lytic bone lesions, subchondral cysts, and larger carpal cysts may be prominent features.²³⁻²⁵ Early hypotheses for the mechanism of the erosive changes included an extension of subperiosteal resorption along the shaft of a bone into the adjacent joint¹¹ or a pyrophosphate-like arthropathy.²⁶

The beta-2 microglobulin component of dialysis-related



Figure 3. Hand arthropathy. Poorly defined erosions are present at distal interphalangeal, proximal interphalangeal, and metacarpophalangeal joints. There is destruction of the distal interphalangeal joint of the index finger. Extensive subperiosteal bone resorption is also evident at multiple sites.



Figure 4. Spondyloarthropathy. Same patient as in Figure 2. There is disc destruction, endplate erosion, and partial collapse of vertebral bodies.

amyloid protein is now recognized as a cause of carpal tunnel syndrome, and its presence has been found to increase with increasing duration of hemodialysis.²⁰ Appendicular erosions and lytic bone lesions are now known to be related to the presence of this amyloid material.^{24,25,27} Amyloid deposits have also been found within discs and peridiscal ligaments in the setting of destructive spondyloarthropathy,¹⁸⁻²⁰ suggesting this as a common pathogenesis for appendicular and axial arthropathies.

The concurrent presence of spondyloarthropathy and appendicular arthropathy in three of our patients supports this theory.

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Chorionic villus sampling: The University of Maryland experience

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The University of Maryland was the first program in the state to offer chorionic villus sampling (CVS). Since the program's beginning in 1984, 998 patients have been seen with successful sampling in 99.1 percent, using both transcervical and transabdominal approaches. The overall loss rate was quite low (2.3 percent), and no increased risk of birth defects was seen. These observations demonstrate that CVS provides a safe and accurate alternative to amniocentesis.

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In the decade since the introduction of chorionic villus sampling (CVS) as a clinical diagnostic tool, the procedure rapidly has been accepted as a first-trimester alternative to amniocentesis. Over these ten years, several studies have provided information on the safety, efficacy, and reliability of CVS.¹⁻⁴ We present our experience at the University of Maryland in the first seven years of the CVS program—the first program in Maryland offering this technology.

Materials and methods

This study details the program's results from March 1984 through February 1991. Of the 998 CVS procedures performed, 978 were first-trimester procedures on singleton pregnancies and comprise the study group of this report. The major indication for the procedure was advanced maternal age, accounting for over 95 percent of the procedures performed. First-trimester CVS also was performed in nine multiple pregnancies (eight twins; one set of triplets). Eleven late CVS procedures (greater than 13 weeks gestational age) were performed, with the major indication being an ultrasound-detected fetal malformation.

At the time of the CVS, gestational age was determined by a combination of the last menstrual period and standard ultrasonographic biometric parameters. For patients in whom the gestational age determined by ultrasonography was discrepant by more than two weeks, gestational age by ultrasound was used.

CVS was performed from the ninth to the thirteenth week of gestational age, using either a transcervical or a transabdominal approach. Transcervical samplings were obtained using a 16-gauge polyethylene catheter (**Figure**) as previously described by Hogge et al and by Ferguson et al.^{5,6} In no instance were greater than three attempts made, and a new catheter was used for each insertion.

Transabdominal CVS was performed using a 20-gauge spinal needle. Using a sterile ultrasound-guided technique, either a biopsy-guide or a freehand approach was employed, depending on operator preference. After the needle was placed into the placenta, aspiration was performed using a 20 ml syringe containing 1–2 ml of Hanks balanced salt solution. Approximately 15 ml of suction was applied, and the needle was moved backward and forward vigorously within the placenta.

There were no specific contraindications to chorionic villus sampling except for an inaccessible placental location; most commonly, CVS was not attempted if there was a severely retroverted uterus with a posterior placenta. In the presence of an active herpes infection, a transabdominal approach was used, if technically possible. If not, the procedure was not performed.

An adequate sample was defined as at least 10 mg wet weight of villus material. For chromosome analysis, both direct preparations, and cultured cells were examined, but only culture results were reported to the patient.

Results

There were 978 first-trimester procedures performed, 744 of which were transcervical CVS and 234 were transabdominal. The majority of transcervical CVS procedures (84.5 percent) were successful on the first attempt, with only four patients requiring three attempts to obtain a sample. Successful sampling was performed in 99.2 percent of patients undergoing transcervical CVS. For transabdominal CVS, a sample was obtained on the first attempt in 88.5 percent; in three patients, sampling was unsuccessful by the transabdominal approach. Overall, the successful sampling rate with transabdominal CVS was 98.7 percent.

There were 25 pregnancies terminated following chorionic villus sampling because of an abnormal result (20) or for elective reasons (5). Of the 953 pregnancies "intended to continue," 22 were spontaneously aborted, representing an overall loss rate of 2.3 percent. The loss rate for transabdomi-

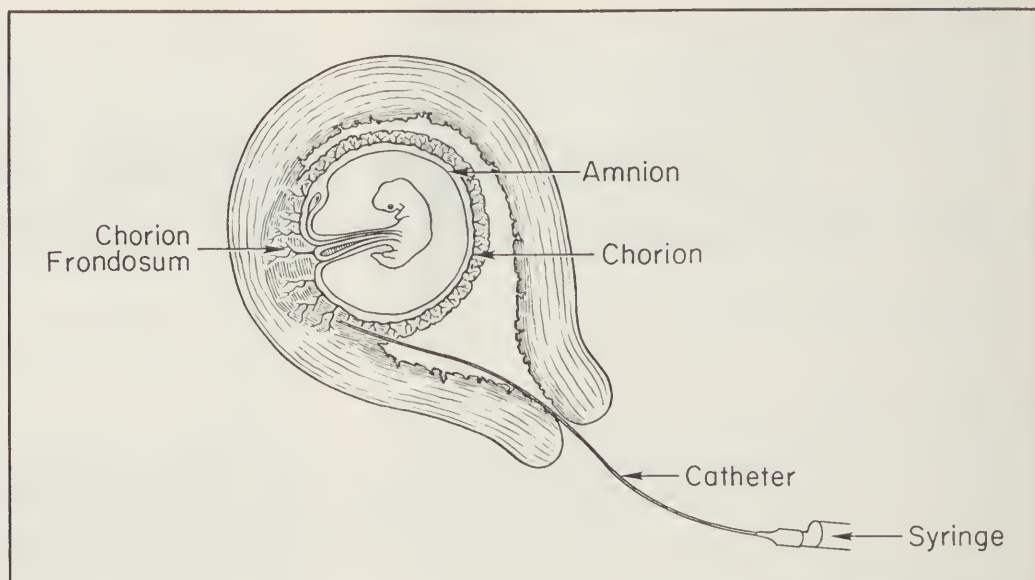


Figure . A uterus at 10-week gestation with catheter positioned in the chorion frondosum

nal CVS was 2.6 percent compared with the transcervical rate of 2.2 percent, a nonsignificant difference. Of the 78 procedures performed between 12 and 13 weeks menstrual age, only two losses occurred. This rate, likewise, is not different from the overall rate for spontaneous loss.

The incidence of nonmosaic chromosome abnormalities was 1.7 percent. Mosaicism was detected in 11 cases (1.1 percent), but in only three of these cases were the abnormalities confirmed, either on amniotic fluid cells or fetal tissue. This represents a true abnormality rate of 27.3 percent when a mosaic result is detected by CVS.

All 931 continued pregnancies have now delivered. Although ascertainment is still incomplete, only nine birth defects have been reported following CVS—a rate of 0.97 percent. No limb abnormalities have been observed following chorionic villus sampling.

Discussion

Chorionic villus sampling has gained wide acceptance over the last seven years, both at the University of Maryland and worldwide. From its beginning in the infancy of CVS development to the present, our program has grown to an average of ten patients per week undergoing CVS. Much of the technique's popularity can be traced to the earlier availability of results and the relatively painless nature of this procedure.

Other studies have shown the safety, efficacy, and accuracy of this diagnostic modality, and our results confirm those findings.^{1–4} More than 99 percent of patients will have successful sampling, most with only one pass of the catheter or needle. The total loss rate of 2.3 percent in this study is quite low and compares favorably with large programs and with those programs with a limited number of operators.^{6,7} Without a control group, it is impossible to calculate true procedure risks, but other studies have shown a background loss rate at this stage of pregnancy to be 2–3 percent.⁸ Therefore, it would

appear that in an experienced program, the loss rate directly attributable to the procedure approximates 0.5 percent or less, a rate quite comparable with amniocentesis.

Our results support previous studies indicating that CVS is not associated with an increased risk of birth defects. In addition, no limb abnormalities were seen following CVS, contrary to the concern raised in a recent report.⁹ We believe these differences relate to our strict guidelines for only sampling after nine menstrual weeks and to the experience of the operators in this program. It is likely that limb abnormalities, if observed, are related to earlier sampling (prior to nine weeks) and a transabdominal approach, factors that may result in significant disruption of the placental bed and/or marked uterine contractions.

In other studies, confined placental mosaicism has been noted to represent a diagnostic dilemma.^{3,4} In our experience, the incidence of this finding was 1.1 percent, but in only one-quarter of these patients did the result truly reflect the fetal chromosome constitution. In all patients with mosaicism, amniocentesis should be performed to confirm the observations. Most cases of mosaicism will be confined to the placenta and will not be found in the fetus. Our numbers are too small to address the question raised previously of poor obstetric outcome in patients with confined placental mosaicism, but no trend was noted.

In summary, the University of Maryland's experience with almost 1,000 cases confirms the safety and reliability of chorionic villus sampling. Our experience supports the concept that loss rates can be minimized even in programs where multiple (4) new operators are added to the program over the course of seven years. We believe our success is due to the requirement that all new operators become thoroughly experienced in the technique on pregnancies with planned elective termination. Integration into the clinical program is accomplished under the direct guidance and supervision of an experienced operator. Based on our data and that from the literature, we believe that CVS is a safe, accurate prenatal diagnostic method, offering patients the benefit of first-trimester diagnosis.

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The above report illustrates two of the superb qualities that made John Dennis, M.D. an outstanding dean:

- He recognized programs that would improve health care for the citizens of Maryland and increase the scientific knowledge emanating from our institution; and
- he was a man of his word.

During the winter of 1981-82, Dr. Dennis was quite impressed with the proposal made by Maimon Cohen for developing a Division of Human Genetics in the Departments of Obstetrics and Gynecology and of Pediatrics. He quickly recognized the need for such a program and appreciated the uniqueness of it in that it was to be based in two departments vitally interested in human genetics.

When Dr. Dennis made a promise regarding the provision of resources necessary for faculty to do their job, he always kept that promise. In addition to supporting our efforts in genetics with resources from the School of Medicine, he convinced the hospital administration to invest some of their very scarce resources in this program. Both the School of Medicine and the hospital have been amply repaid for the financial investment by both institutions.

Generations of Marylanders will profit from John Dennis' foresight.



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Hemoglobin as oxygen carrier in cell-free fluids

Enrico Bucci, M.D., Ph.D. and Clara Fronticelli, Ph.D.

From the University of Maryland at Baltimore, Department of Biological Chemistry, where Dr. Bucci is professor and Dr. Fronticelli is professor.

The University of Maryland is studying the oxygen needs of internal organs and how these needs can be met by oxygen carriers in cell-free fluids. Once developed, cell-free oxygen carriers will have a large variety of applications including hemodiulution, transfusion therapy, organ preservation, and cancer therapy.

Blood transfusion is a major tool in health care delivery, and the demand for safe blood is continually increasing. It can be safely assumed that when a cell-free oxygen carrier becomes available, it will have a large variety of applications and provide the means for further development of new medical procedures. While it is presently impossible to reproduce a system that incorporates all the characteristics of whole blood, a red cell substitute would present several advantages, such as virus-free solutions, unlimited availability, and universal use. Obvious applications are hemodilution and transfusion therapy; others can be envisioned such as organ preservation, reperfusion of ischemic tissues, cell culture media, treatment of systemic anemias as in sickle cell disease or thalassemia, and cancer therapy. Many others will become obvious with usage of the new technology.

Historical background

The history of the development of blood substitutes goes *pari passu* with catastrophic events associated with loss of blood, such as wars and natural disasters. Early attempts to transfuse animals with homologous or heterologous blood were made in 1875 by Smith¹ after the carnage of the American Civil War. The occurrence of intravascular coagulation and nephrotoxicity was found to be linked to the lipids of the erythrocytes stroma. Research remained dormant until World War I broke out in Europe in 1914, reviving the urgent necessity for fluid replacement to save young lives. Successful attempts were made using either isotonic solutions of crystalloids² or solutions containing cell-free oncotic agents (i.e. plasma expanders) of various natures, including gum and dextrans.² The development of advanced technology for collection and utilization of blood and its fractions provided the clinician with a vast array of plasma expanders that could be used for resuscitation. These substitutes included starch and dextran solutions, solutions of serum albumin, and whole blood. The development of this technology allowed the standardization of new clinical and surgical techniques, including very complex procedures based on extracorporeal circulation.

The increasing demand for blood products revealed limitations such as a shortage of donated blood, short shelf life of blood, transmission of viral infections, and allergic reactions not anticipated by cross matching techniques. It became clear that it would be very useful to obtain a cell-free transfusion solution that would combine the characteristics of a plasma expander with the capacity to transport oxygen from the lungs to the tissues. In blood, hemoglobin is the oxygen carrier inside the erythrocytes; an isotonic solution containing cell-free hemoglobin would confer to an infusion fluid both oncotic pressure and oxygen transport.

One of the most prominent pioneers in the development of a hemoglobin-based oxygen carrier was Dr. William R. Amberson, chairman of the Department of Physiology of the University of Maryland Medical School. Dr. Amberson experimented extensively with the preparation and use of hemoglobin solutions in animals and in humans. He reported the use of red cell hemolysates in fourteen patients, seven of whom had repetitive infusions.³ He noticed that following transfusion, there was an elevation of blood pressure associated with a diminished heart rate; in most of the cases, the general condition of the patients improved and the hematocrit values were increased. Hemoglobin was retained in the circulation for a few hours, and a maximum of 25 percent was eliminated in the urine during a period of 30 hours. In some cases, oliguria was observed associated with a reduction of the glomerular filtration rate and renal plasma flow, with later recovery to normal. These effects were more evident in patients who received multiple infusions. Amberson attributed these effects to the presence of cellular debris from the erythrocyte membranes in the infusion solutions. He indicated the necessity of extensive careful investigations using standard preparations of hemoglobin solutions with the warning that "the field is a difficult one, beset with many hazards."³

Hemoglobin as cell-free oxygen carrier

Hemoglobin is a tetrameric protein formed by two pairs of α - and β -subunits. As shown in **Figure 1**, the tetrameric and dimeric forms are in equilibrium in oxygenated hemoglobin. When hemoglobin is inside the erythrocytes, the dimers are not released; however, in cell-free solutions, the dimers are rapidly filtered through the capillary walls and, in less than an hour, most of the infused hemoglobin disappears from plasma. A massive hemoglobinuria is produced and at least 30 percent of the infused material is recovered in the urine. **Figure 1** shows the dissociation of tetrameric hemoglobin followed by urine elimination.

Hemoglobin is the protein within the erythrocytes that transports oxygen from the lungs to the tissues. The oxygen affinity of hemoglobin in the red cells is controlled so that oxygen is absorbed at the lungs and re-

leased to the tissues. The affinity of hemoglobin for oxygen, P_{50} , is measured by the partial pressure of oxygen necessary for producing 50 percent saturation. **Figure 2** shows the oxygen-binding curve of whole blood as compared with that of a cell-free solution of hemoglobin. In both cases, the curve is sigmoidal, indicating heme-heme interaction. The P_{50} of whole blood is near 28 mmHg; the oxygen binding curve of cell-free hemoglobin is shifted toward the left and the P_{50} is near 15 mmHg. This implies that cell-free hemoglobin has a higher oxygen affinity, which would prevent the release of oxygen to the tissues. The difference in oxygen affinity between whole blood and hemoglobin is due to the presence, within the erythrocytes, of an organic polyphosphate, namely 2,3 diphosphoglycerate, which combines with hemoglobin,

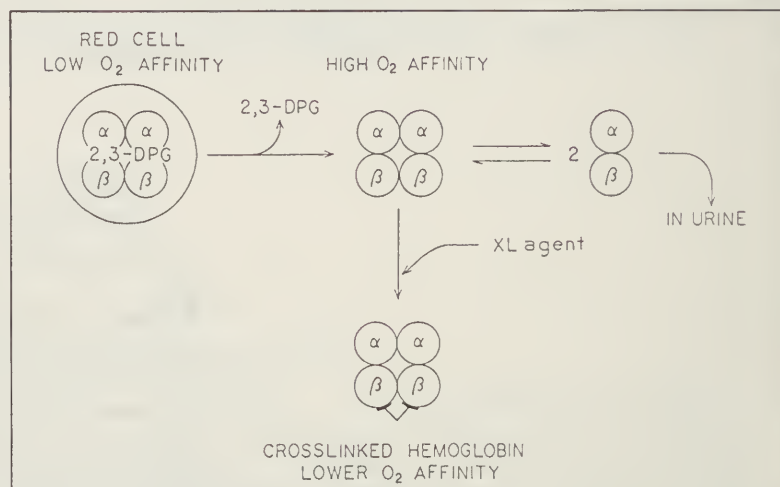


Figure 1. Schematic representation of tetrameric hemoglobin which, inside the erythrocytes, combines with 2,3-diphosphoglycerate (2,3-DPG). In pure solution, it dissociates into dimers which, in turn, are eliminated in the urine. Crosslinked hemoglobin molecules do not dissociate into dimers and are retained by the kidney.

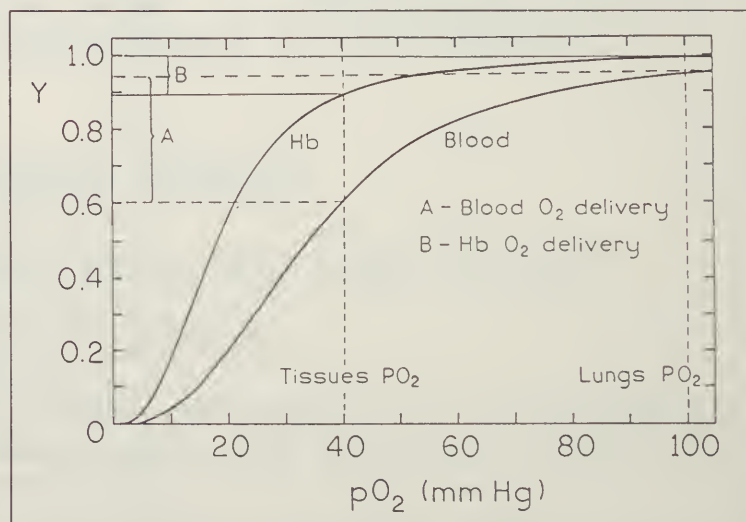


Figure 2. The figure shows oxygen-binding characteristics of whole blood and of pure hemoglobin. The figure also shows the fraction of bound oxygen that is delivered to the tissues by the two carriers. The delivery from pure hemoglobin is much less than from whole blood. Measurements were performed at 37° C at pH 7.4 in 10 mM phosphate buffer, 25 mM sodium bicarbonate, and 65 mM sodium chloride in the presence of carbon dioxide at the partial pressure of 40 mmHg.

thereby decreasing its oxygen affinity to a level that assures efficient oxygen transport. This interaction is lost in cell-free conditions.

It is clear that the use of hemoglobin in transfusion fluids requires manipulations for preventing its dissociation into dimers and for decreasing its oxygen affinity to physiologically acceptable levels.

Transformation of hemoglobin into a viable oxygen carrier

There is a vast literature on the attempts to transform hemoglobin into a viable oxygen carrier.⁴ As discussed, the main difficulties to be overcome in the design of hemoglobin-based oxygen carriers are: (a) the high oxygen affinity of cell-free solutions of hemoglobin; (b) the short retention time in circulation, resulting from the rapid filtration of the dimers through the endothelial walls of the capillaries, especially in the renal glomeruli; and (c) the complete removal of stromal residues which are toxic. To overcome these problems several approaches have been explored.

Chemical modifications. Chemical modifications are used to confer to hemoglobin an oxygen affinity similar to that of blood and to impede the dissociation into dimers. These modifications can be grouped into different categories for which only the most relevant literature is reported here.

1. Modifications that decrease the oxygen affinity such as carboxymethylation of the amino terminal residues⁵ and pyridoxylation of the β -subunits,⁶ and fumaryl-acylation of the lysines of the β -chains.⁷
2. In pseudo-crosslinked hemoglobins, the formation of dimers is inhibited by chemical modifications that produce extra hydrophobic and electrostatic bonds between hemoglobin subunits.^{8,9}
3. Intramolecularly crosslinked hemoglobins introduce a covalent crosslink between the α - or β -subunits.^{7,10} This modification totally prevents the dissociation of hemoglobin into dimers. As shown in Table 1, the introduction of these crosslinks, in some cases, also reduces the oxygen affinity of hemoglobin to a level similar to or lower than that of blood.

Table 1. Oxygen affinity characteristics of human and bovine hemoglobins treated with mono- and di-ester derivatives of 3,5-dibromosalicylate.

Compound #	Hemoglobin	Reagent	P ₅₀ (mmHg)	n
1	HbA	FBDA	11	2.0
2	HbBv	FBDA	17	1.8
3	HbA	FMDA	26	1.9
4	Hbv*	FBDA	27	2.3
5	HbBv	FMDA	38	1.8
6	HbBv	FBDA	45	1.9

Measurements performed at pH 7.4 in 0.1 M tris buffer with 0.1 M Cl⁻ at 37° C in the presence of 5 percent CO₂.

FMDA = Fumaryl-mono-DA HbA = Human hemoglobin Ao

FBDA = Fumaryl-bis-DA HbBv = Bovine hemoglobin

DA = 3,5-dibromosalicylate

n = Extent of heme-heme interaction (blood, n=2.8)

* = Obtained from deoxyhemoglobin

4. Intermolecularly crosslinked hemoglobins are polymeric hemoglobins of molecular weight (MW) between 100,000 and 1,000,000 (normal hemoglobin MW = 64,000). An advantage in the use of polymeric hemoglobins is their low oncotic pressure that allows their use in high concentration, increasing the oxygen-carrying capacity of the perfusion fluids.⁴ The crosslinkers used are nonspecific in their chemical reactions, resulting in random chemical substitutions which, in turn, produce largely heterogeneous materials, difficult to standardize and characterize.
5. Conjugated hemoglobins are hemoglobins coupled to large molecular weight matrixes like dextran, polyvinyl-pyrrolidone, and polyethylene glycol.⁴ These oxygen carriers are also heterogeneous and, due to the inert nature of the supporting matrix, the amount of oxygen transported per unit weight is uncertain.

Preparation of highly purified solutions of hemoglobin.

According to Amberson et al,³ conflicting results and claims on the efficacy and side effects of hemoglobin-saline solutions were due to the different preparative procedures used in different laboratories. This problem is still present. Modern technology offers a variety of means for purifying hemoglobin from hemolysates. These include filtration devices and centrifugation machines for large scale chromatography. Quality control tests enable investigators to analyze and evaluate the standardization of their preparations. Still, there is not a consensus on a common purification method that would allow better comparative evaluation of the various products. The high cost of these procedures is a severe limiting factor for animal experimentation, which requires large amounts of hemoglobin solutions.

Possible hemoglobin sources

The main source of human hemoglobin comes from outdated units of blood and this supply is limited. Concern for nondetectable viral infections is also high. A solution to this problem would be to use blood from other large mammals. The use of bovine Hb has been explored and a product is available commercially as cell culture media. Bovine hemoglobin is particularly suitable because in physiological conditions, it has an oxygen affinity similar to that of blood, even in cell-free conditions. Recent concerns about its use are due to the finding of the bovine spongiform encephalitis agent in European cows. This agent is thermostable and can remain dormant for many years.

Molecular biology has provided an alternative source of hemoglobin by introducing in microorganisms such as *E.coli*, expression vectors for human hemoglobin.¹¹ A company, Somatogen, claims it is starting industrial production of recombinant human hemoglobins. Unfortunately, these products are under proprietary custody and are not available for rigorous scientific evaluation.

Development of hemoglobin-based oxygen carriers at the University of Maryland.

Purification of hemoglobin samples. The University of

Maryland's acquisition of a large-scale preparative liquid chromatography apparatus allowed the standardization of procedures for obtaining chromatographically pure oxygen carriers in quantities sufficient for *in vivo* trials on rats, cats and dogs. It is a labor intensive technique that involves chromatographies, filtrations, isovolumetric dialyses, and detoxification steps. This technique assures reproducibility of the prepared oxygen carriers.

Chemical modifications of hemoglobin. The authors have developed a family of oxygen carriers based on the observation reported by Dr. Klotz at Northwestern University¹² that a derivative of aspirin, namely 3,5-dibromosalicylic acid, is a specific receptor group for the lysines at position 82 in the so called β -cleft of hemoglobin, where hemoglobin binds 2,3-DPG. The double ester of fumaric acid (COOH-CH=CH-COOH) with 3,5-dibromosalicylic acid produces a covalent crosslink between the β 82 residues of the partner β -subunits of hemoglobin, thereby preventing its dissociation into dimers (Figure 1). Fumaric acid can be replaced by a variety of polycarboxylic acids so as to obtain a group of reagents with high specificity for the β 82 residues of hemoglobin. These reagents have been used to prepare a large family of oxygen carriers with similar molecular and physico-chemical characteristics and with oxygen affinity between 10 and 50 mmHg. Sedimentation velocity measured in the analytical ultracentrifuge indicates that they behave as nondissociable tetramers. This anticipates longer retention time in circulation and decreased or null urine elimination after infusion into animals. The functional characteristics of these products are listed in Table 1. The range of oxygen affinity covered by this family of hemoglobin derivatives is graphically presented in Figure 3. The bold line is the oxygen binding curve of whole blood. For these studies, either human or bovine hemoglobins were used, with similar results.

Animal experimentation. There are many reports of altered renal function upon injection of natural hemoglobin or hemoglobin derivatives. These negative effects have been attributed to impurities present in the preparations used for infusion.^{3,4} In collaboration with Dr. Urbaitis in the Department of Medicine and Physiology,¹³ the authors have monitored the renal functions of rats infused with our chromatographically pure solutions of natural hemoglobin or of hemoglobin crosslinked between the β -subunits (compound 2 in Table 1). Hemoglobinuria was absent when the crosslinked derivative was injected; when solutions of natural hemoglobin were used, 30 percent of the infused material was recovered in the urine.

Urine flow (V), the glomerular filtration rate (GFR), and effective renal plasma flow (ERPF) were monitored. In all cases, including controls with injection of bovine serum albumin, we observed a transient increase in GFR, ERPF, and urine flow, suggesting that these alterations were produced by the 8 percent expansion of vascular volume consequent to the bolus injection.

Within 1 hour, these functions returned to normal values which were maintained after 48 hours. These data are shown in Table 2.

These results confirmed Amberson's expectation³ that the use of purified hemoglobin solutions prevents renal dysfunction and that the extensive hemoglobinuria occurring upon injection of unmodified hemoglobin does not produce lethal or irreversible kidney damage.

Molecular design of hemoglobin-based oxygen carriers by genetic engineering. The gene of the β -globin has been introduced in *E. coli*, and techniques of molecular biology can be used for introducing selected amino acid substitutions in the expressed protein. New mutant hemoglobins can be designed in which the functional characteristics can be tailored to specific needs. The authors are developing recombinant mutant human hemoglobins whose oxygen affinity will be regulated by anions physiologically present in plasma-like Cl^- and HCO_3^- . These will produce oxygen carriers whose oxygen affinity is modulated by the metabolic needs of the infused organism and by possible clinical interventions.

Conclusion

An institutional program for conducting systematic experiments leading to a better understanding of the oxygen needs of internal organs and how these needs can be met by oxygen

Table 2. Renal function data 48 hours after 60 to 100 mg per 100 gm⁻¹ albumin, HbA, and HbBvFBDA.

	Dose (mg/ 100 gm)	n	V ($\mu\text{l/min}$)	GFR ($\mu\text{l/min}$)	ERPF ($\mu\text{l/min}/$ 100 gm)
Albumin	100	4	3.5 ± 0.2	449 ± 24	1168 ± 98
HbA	60	5	3.5 ± 0.1	451 ± 50	1317 ± 144
HbA	100	6	3.9 ± 0.1	385 ± 57	1095 ± 199
HbBvFBDA	100	2	3.2 ± 0.2	489 ± 40	1329 ± 219

V = urine flow
ERPF = effective renal plasma flow
HbBv = bovine hemoglobin
GFR = glomerular filtration rate
HbA = human hemoglobin Ao
FBDA = fumaryl-bis-DA

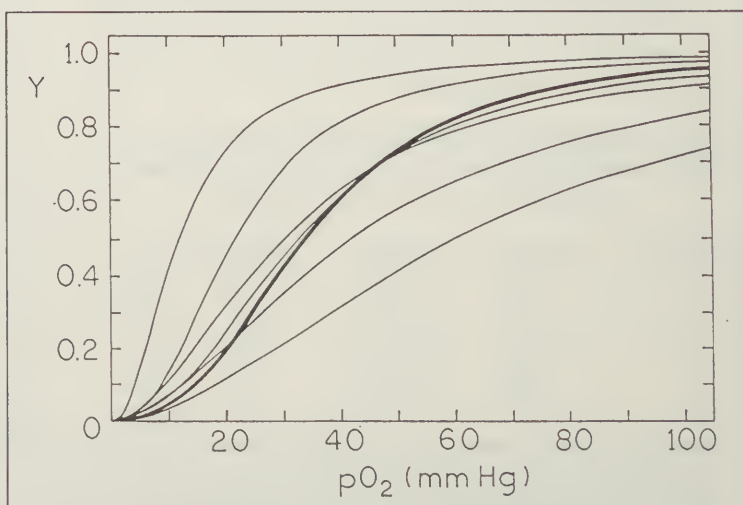


Figure 3. Representative oxygen-binding curves of the oxygen carriers listed in Table 1, compared with that of whole blood (thick line). Measurements were performed as described for Figure 2.

carriers in cell-free fluids is developing at the University of Maryland. The program is multidisciplinary, spanning from the physical chemistry of hemoglobin molecules to the physiology of oxygen transport in normal and hypoxic animals. The efforts involve the expertise of physical chemists, biochemists, molecular biologists, surgeons, anesthesiologists, and physiologists.

At present, the availability of a variety of chromatographically pure oxygen carriers, retained by the kidney and with reduced or null toxicity is a facility unique to the University of Maryland. If our efforts are successful, it will give the University of Maryland national prominence in the field of hemoglobin-based oxygen carriers.

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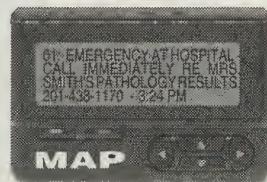
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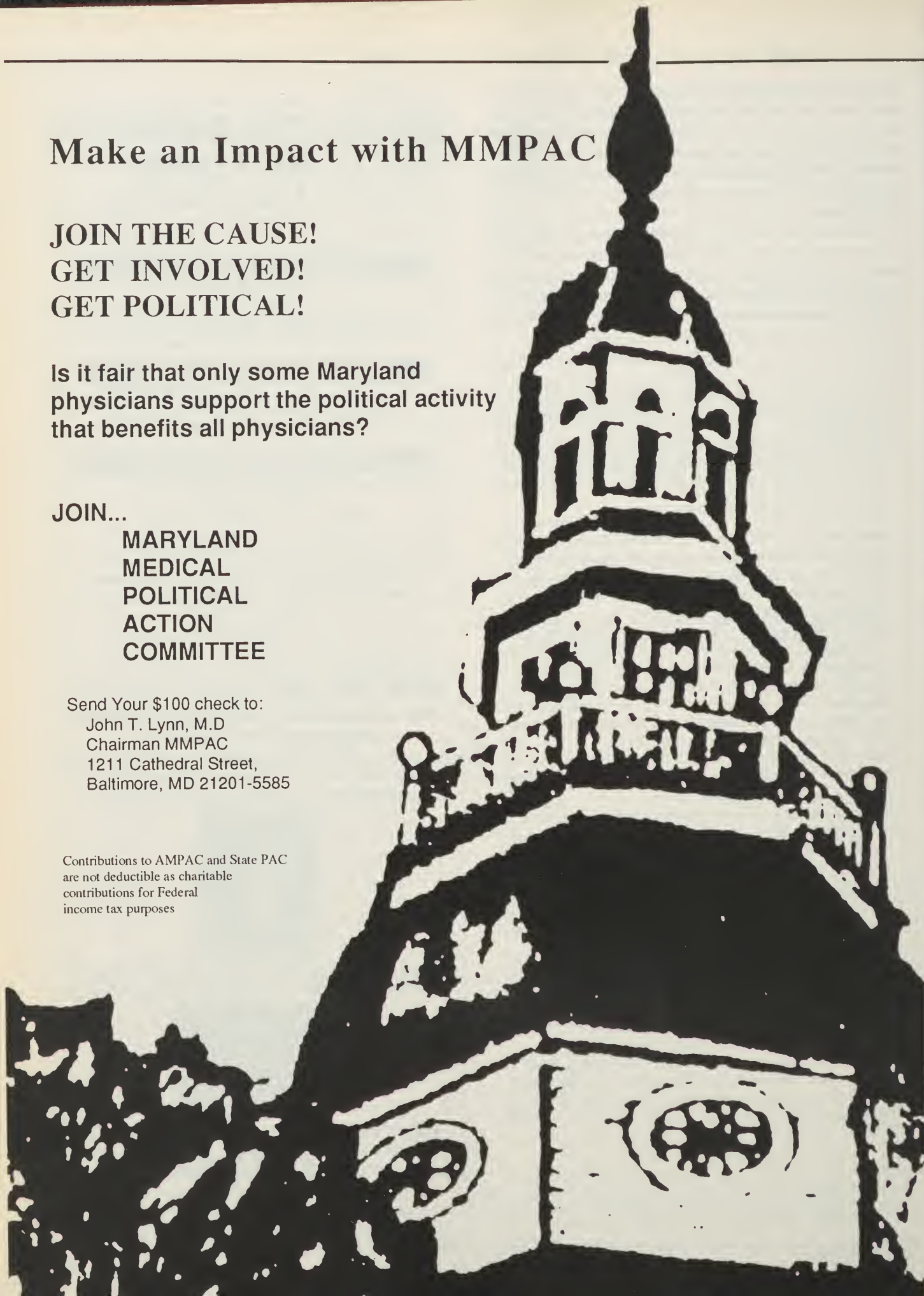
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A new concept of hemorrhagic shock: Implications for therapy

Donald S. Gann, M.D. and John A. Evans, Ph.D.

Dr. Gann is professor and associate chairman, Department of Surgery, University of Maryland School of Medicine. Dr. Evans is assistant professor, Departments of Surgery and Biological Chemistry, University of Maryland.

Although historically shock has been viewed in terms of circulatory failure, in recent times, the defect in shock has been thought to result from a failure of oxygen delivery.

Although historically shock has been viewed in terms of circulatory failure, in recent times, the defect in shock has been thought to result from a failure of oxygen delivery. Thus, in hemorrhagic shock, as a result of decreased venous return, cardiac output falls and, consequently, the delivery of oxygen to tissues does as well. With the finding by Shires and his colleagues in the 1970s that membrane depolarization (a decrease in the absolute value of the transmembrane potential) is a constant finding in shock,¹ a modern view of the pathogenesis of shock has been developed. According to this view, as oxygen delivery fails, cells are unable to generate sufficient quantities of ATP (adenosine triphosphate). As a result, the electrogenic sodium pump, mediated by the hydrolysis of ATP by the sodium- and potassium-dependent ATPase (adenosine triphosphatase), fails; the membrane depolarizes; and sodium and water accumulate within the cell as potassium is lost from it.² The cell swells, leading to further derangements in cellular function. Membrane depolarization has been observed in septic shock as well as in hemorrhagic shock, and these events have been thought to provide the linkage between circulatory failure, identified as critical by early workers in the field of shock, and cellular and organ dysfunction, identified more recently.

Several lines of evidence have developed that appear incompatible with the views summarized above. First, membrane depolarization has been observed after levels of hemorrhage that should not severely limit oxygen delivery or, consequently, ATP formation.³ Second, membrane depolarization has been observed in sepsis before the onset of hemodynamic destabilization and the onset of true septic shock.⁴ Third, and most significant, the red blood cell has been found to exhibit membrane depolarization, both in hemorrhagic and in septic shock.^{4,5} The red blood cell synthesizes ATP as a result of glycolysis, a process independent of oxygen consumption. Indeed, although the red blood cell carries oxygen, it does not consume it, but rather uses glucose as its fuel. Glucose is readily available to the red blood cell, and this availability is not limited in shock.

It is also apparent that the red blood cell possesses neither a microcirculation nor innervation. These various lines of evidence led to the consideration of the possibility that there might be a humoral factor circulating in shock that might somehow mediate depolarization of the cell membrane.⁶

If the magnitude of hemorrhage is not too great, blood volume lost by hemorrhage is restored by physiologic processes that depend upon the neural and hormonal responses to hemorrhage.⁷ Full restitution of blood volume after hemorrhage depends on the movement of fluid from cells into the extracellular and extravascular interstitium and, subsequently, the movement of water and protein into the vascular compartment.⁸ The movement of fluid out of cells is driven by a transient osmotic gradient that is generated by the production of solute from the liver in response to the elevation of a number of hormones triggered by hemorrhage, including cortisol, the catecholamines, vasopressin, and glucagon. The failure of any of these hormones to rise after hemorrhage can limit the degree of restitution of blood volume and protein. On the other hand, we have found that as the magnitude of hemorrhage increases, there is a critical point reached at approximately 25 percent of the blood volume beyond which larger hemorrhage does not lead to full restitution of blood volume.⁹ This is the same magnitude of hemorrhage at which Shires and his colleagues have found the onset of membrane depolarization.¹⁰ We have examined this situation quantitatively in our own laboratory and have found that the degree of water and salt movement into cells, as a result of membrane depolarization, can account precisely for the failure of restitution of blood volume after large hemorrhage. Indeed, the amount of membrane depolarization required to produce the degree of cell swelling that would offset the physiologic restitution is precisely that measured previously by Shires and his colleagues.

Stimulated by this finding and by the evidence summarized above that suggested a humoral factor, we have sought evidence for the presence of such a factor in hemorrhagic shock. We chose to study the plasma of rats subjected to hemorrhage in the absence of anesthesia or surgical manipulation. The rats were subjected to hemorrhage at five days after cannulation of the aorta and vena cava, following which they were allowed to readapt to their cages, eat and drink freely, and move about the cage without restraint. We found that within a few minutes after the onset of a major hemorrhage, a factor appeared in rat plasma that could depolarize cells. The amount of this factor continued to rise after hemorrhage of 30 percent of the blood volume, reaching a peak at twenty minutes which was sustained for the duration of the experiment. The factor was restrained by a dialysis membrane that indicated its molecular weight to be in excess of 10,000 daltons. In the process of this dialysis, plasma was equilibrated with buffer to ensure constant pH and ionic composition. Exposure of a variety of cells to very small amounts of dialyzed plasma for short periods of time led to depolarization, measured by a voltage sensitive dye.¹¹ The methods that we employed avoided possible arti-

facts generated from the puncture of cells by microelectrodes, and gave independent confirmation of the degree of depolarization of membrane identified by the Shires group.¹⁰ The dialyzed rat plasma depolarized red cells, white cells, smooth muscle cells, striated muscle cells, and kidney, liver, and adrenal cells of the rat, and also depolarized cells derived from mice, cats, dogs, pigs, and human beings. These results indicated a lack of dependence of either cell type or species. The finding that red cells depolarized was of particular interest since this result was consistent with the findings in red cells in hemorrhagic and septic shock. Furthermore, the various cell lines were not deprived of oxygen, indicating that hypoxia in the target cell was not required for membrane depolarization. Hypoxia, however, might be important in mediating production of the factor. We examined the binding kinetics of the factor to cells and demonstrated equilibrium kinetics indicative of binding of the factor to a membrane receptor.¹¹

Because the measurement of membrane potential might be the result of some methodological artifact, we have sought independent confirmation of membrane depolarization by other methods. These alternative approaches have confirmed depolarization of cell membranes and have permitted identification of the active substance as a high molecular weight protein.

These findings provide a new avenue for the study of shock and trauma, and also suggest a possible approach to therapy. Because the factor is a protein, it is possible that monoclonal antibodies to it may interfere with its action and may offer a therapeutic intervention analogous to that currently being attempted with antibodies to endotoxin or to tumor necrosis factor. Alternatively, the demonstration that the factor acts through binding to a membrane receptor offers the possibility of developing a specific receptor blocker that may interfere with its action. However, the ubiquitous distribution of the factor and of receptors for it raises the possibility that this as yet unidentified substance may play an essential role in normal human physiology, precluding the desirability of total blockade. Clearly, more work is required to provide precise identification of the factor, to elucidate its mechanism of action and modes of control, to examine its production in a variety of forms of shock, and to demonstrate the effect of blocking its action. Nevertheless, the findings at the present offer a novel view of shock as humorally mediated and account for a number of previously uninterpretable findings in hemorrhagic and in septic shock.

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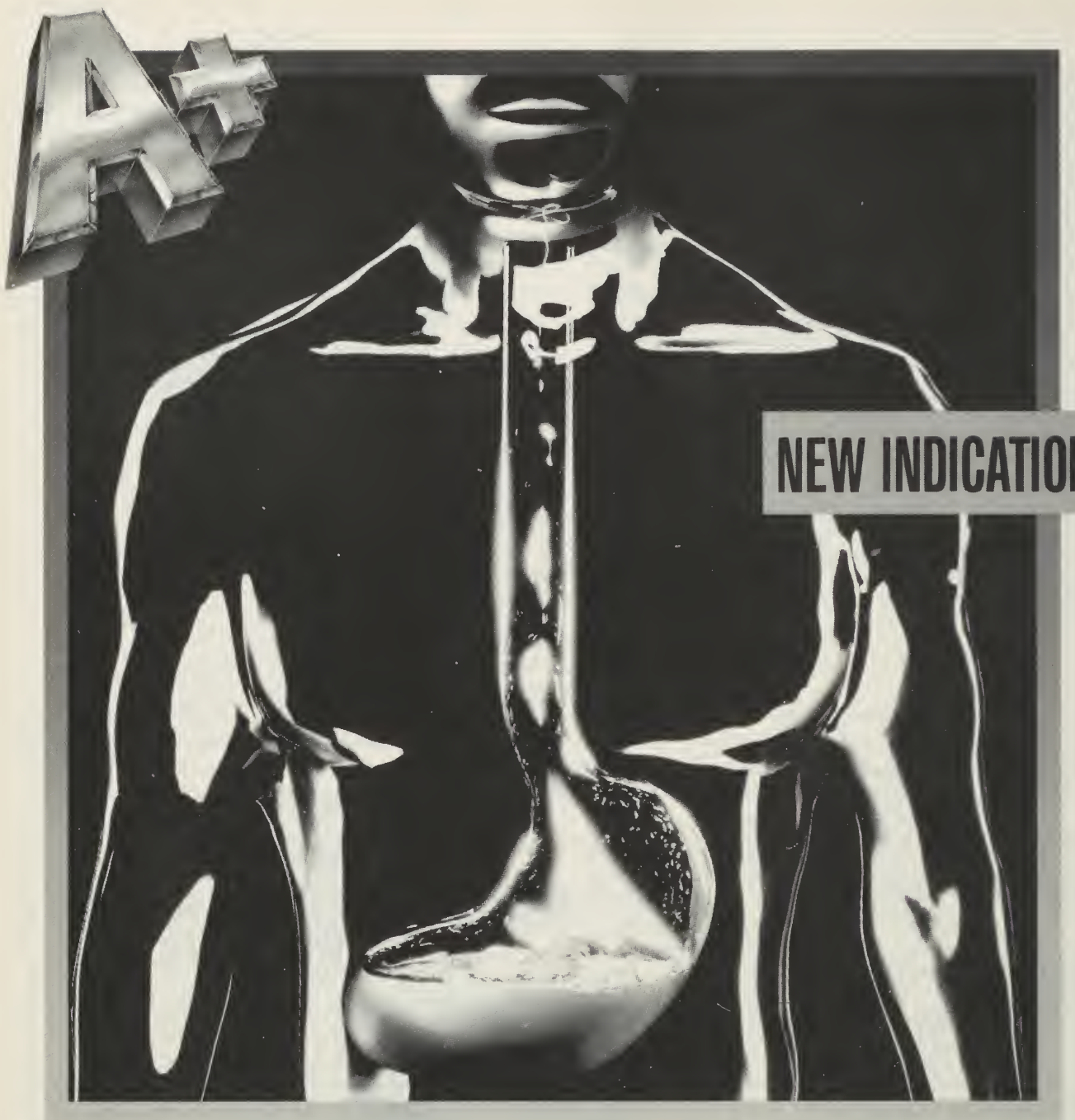
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2. *Maintenance therapy*—for healed duodenal ulcer patients at a dosage of 150 mg h.s. at bedtime. The consequences of therapy with Axid for longer than 1 year are not known.

3. *Gastroesophageal reflux disease (GERD)*—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

Contraindication: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H₂-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H₂-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix[®] may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chloridazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H₂-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H₂-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method. PV 2093 AMP [101591]

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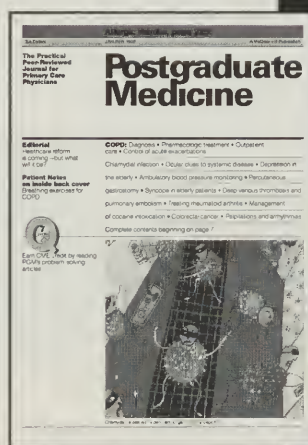


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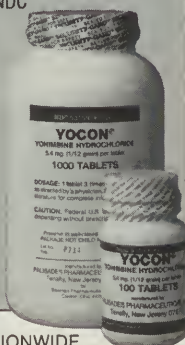
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

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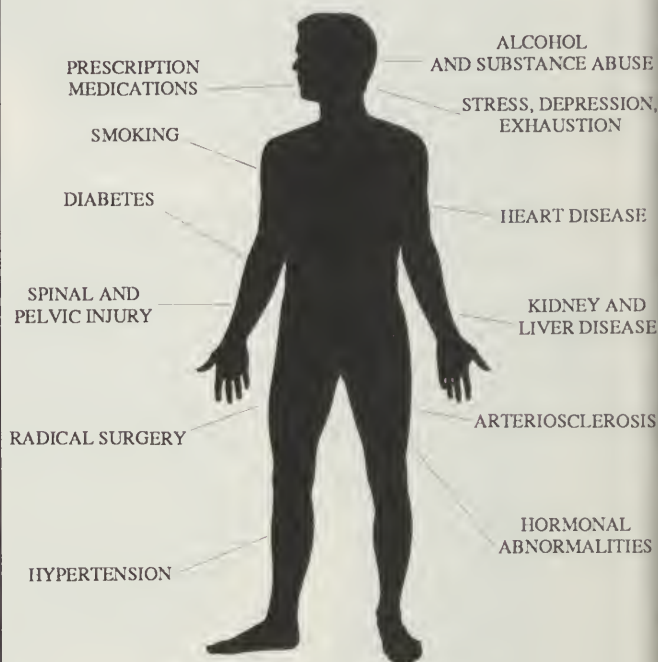


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Auxiliary

A salute to the presidents of the Auxiliary to the Medical and Chirurgical Faculty

This month, we pay special tribute to the forty-two former presidents of the Auxiliary to the Medical and Chirurgical Faculty of Maryland. Some are no longer with us, but we trust they join us in spirit.

The story begins in 1922, when the Women's Auxiliary to the American Medical Association (AMA) was organized. State and county auxiliaries were already in existence in Texas, South Dakota, Maine, Oklahoma, Minnesota, and Montana. In 1949, the AMA was anxious to have auxiliaries in all forty-eight states to help oppose legislative tendencies toward the socialization of medicine. The auxiliary was to function as a liaison between the medical profession and the general public. Its members were to be ready to explain the position of medicine "when the opportunity presented itself" or "when requested."

In September 1949, to comply with the AMA's suggestion, the Medical and Chirurgical Faculty adopted a resolution, at its semiannual meeting in Chestertown, to form a Maryland women's auxiliary.

Two months later, in November 1949, an organizational meeting, with representatives from fifteen counties and Baltimore City, was held with Mrs. Thomas Christensen as acting chairperson. A constitution and bylaws were adopted.

Harry S. Truman was president of the United States and Dr. Austin Pearre of Frederick county was president of Med Chi when the Women's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland was established.

Since that time the auxiliary has grown and flourished under the able leadership of the following women.

Kitty Christensen (Mrs. Thomas) 1950–51. Under the first president, organization and indoctrination were the chief concerns of the year. The national plan for auxiliary work was followed, and educational programs were undertaken. Auxiliaries were organized in six counties and Baltimore City, with 286 members.

Dorothy Yeager (Mrs. George) 1951–52. Counties were informed of the many projects available to them, and were encouraged to evaluate the needs of their local communities.

Margaret Williams (Mrs. Charles) 1952–53. A nurse recruitment program was adopted, and future nurses clubs were established. A recruitment film, *The Girl with the Lamp*, was shown, and nursing scholarships were made available. Civil defense programs were introduced.

By now the nation had a new president; General Dwight D. Eisenhower was elected in 1952.

Monica Ball (Mrs. John G.) 1953–54. The first future nurses convention was held, with twenty clubs taking part. A black and gold president's pin was designed—a replica of a map of Maryland with half a caduceus inscribed thereon. Nursing scholarships were granted.

Elsie Goldstein (Mrs. Albert) 1954–55. Nurse recruitment continued to be a big project, and the first "Student Nurse of the Year" award was presented at the annual convention. The American Medical Education Fund (AMEF) was introduced.

Gaye LeVan (Mrs. Gerald) 1955–56. The number of future nurses clubs increased to 63, with over 300 members. Mental health projects were adopted. State auxiliary membership grew to 571.

Judy Todd (Mrs. Homer) 1956–57. Nurse recruitment, Doctors' Day, legislation, and mental health programs continued to expand throughout the state.

It was about this time that Med Chi moved its annual meeting exhibits out of a tent on the back parking lot at 1211 Cathedral Street to the Alcazar Hotel. Meal functions were moved from Med Chi's basement to the Park Plaza and, subsequently, to the Belvedere Hotel. The faculty's semiannual meetings had previously been held in different locations throughout the state—Cumberland, Hagerstown, and the Eastern Shore. It was now decided to hold the meetings in Ocean City because it was a "nice family place." Headquarter hotels included the Atlantic, the George Washington, and, finally, "way up the beach" at the Commander Hotel on 14th Street.

Selma Clayman (Mrs. David) 1957–58. A safety committee was added, and the auxiliary obtained 396 subscriptions to *Today's Health*, the national auxiliary publication. An official newsletter, *Hygeia Filiae* was published.

The state auxiliary is still publishing *Hygeia Filiae*, which means "Hand Maiden to Health." The name is not quite in keeping with the 90s—it's a bit archaic, as is Medical and Chirurgical Faculty—but the auxiliary plans to keep the name a while longer.

Virginia Shipley (Mrs. E. Rhoderick) 1958–59. County and city activities flourished and there were now 73 future nurse clubs. The wives of medical students at the University of Maryland were organized as a charter chapter in the Women's Auxiliary to the Student AMA (WASAMA).

Dixie Caples (Mrs. Delmas) 1959–60. Activities became more diversified in the components and interest picked up. Allegany, Garrett, and Harford counties joined the organization.

Auxiliary

In 1959, our country's flag added two new states when Alaska and Hawaii became part of the United States.

Louise Stone (Mrs. William) 1960–61. This year, auxiliary programs were expanded even more to meet the increased needs of the counties. A four-county auxiliary chapter was organized by Talbot, Queen Anne's, Kent, and Caroline counties.

In January 1961, John F. Kennedy was sworn in as the youngest president of the United States.

Zara Oliver (Mrs. Norman) 1961–62 The state auxiliary received national awards for its AMA-ERF (Education and Research Foundation) contributions. More emphasis was put on legislation. A Cecil County auxiliary chapter was organized.

"Cappy" Conrad (Mrs. Robert) 1962–63. Membership continued to increase with the organization of yet another auxiliary—Wicomico County. A big event that year was a "Miss Susie Slagle" luncheon to benefit AMA-ERF.

Lyndon Johnson became president of the country, following the assassination of John F. Kennedy.

Mary Hammett (Mrs. Walter) 1963–64. Upon request of the faculty, a representative from the auxiliary was appointed to serve on Med Chi's Public Relations Committee. A Fun(d) Day Benefit Bazaar was held in Osler Hall. The county auxiliaries sold everything from fruitcakes and jewelry to glassware and great whiskey sours. It was truly a fun day.

Arlene Baybutt (Mrs. John) 1964–65. New programs were added, but membership and legislation continued to be most important. An Auxiliary to the Mt. Wilson Hospital was founded by the local medical auxiliary. National AMA-ERF awards were received.

Norma Strobel (Mrs. Martin) 1965–66. The bylaws were revised. To conform to the national auxiliary, the Civil Defense Committee became the Disaster Preparedness Committee, and *Today's Health* became *MD's Wife*. Membership was 915; 23 were members-at-large.

Esther Cohen (Mrs. Archie) 1966–67. An award was received from the Southern Medical Association for the best statewide observance of Doctors' Day. Work on revising the *Auxiliary Handbook* was completed. Due to the illness of Mrs. Cohen and President-elect Bea Sadowsky, Helen Boyer, first vice president, completed the 1966-67 term of presidency.

Louise Stone (Mrs. William) 1967–68. Auxiliary membership increased. A closer relationship with Med Chi was established, and the auxiliary president—the first to serve two terms—was invited to report to the House of Delegates. Elsie Goldstein became the state auxiliary's first honorary member.

Margie Warres (Mrs. Leonard) 1968–69. A state auxiliary pledge was introduced. International health translation team volunteers were enlisted to help alleviate communication problems in area hospitals. The auxiliary served as a cosponsor in the making of a film for nurse recruitment. The year's theme was, "As Others See Us." Mrs. William Stone was made an honorary member.

Richard M. Nixon was elected president of the United States.

Bea Sadowsky (Mrs. Wallace) 1969–70. Membership increased to 962, with 62 members-at-large. The auxiliary was represented on the faculty's Program and Arrangements Committee. Maryland received three national AMA-ERF awards. "Accent on Youth" was the year's theme.

Margaret Yow (Mrs. Raymond) 1970–71. Future nurses clubs were renamed Health Careers Clubs. Monies were raised for Project Hope. The first overnight state board meeting was held.

Polly Reiter (Mrs. Robert) 1971–72. The Anne Arundel County Auxiliary was organized. The first semiannual meeting to be held outside the country met in Puerto Rico, and the luncheon guest of honor was the governor of the Virgin Islands.

Caryl Kolkin (Mrs. Marvin) 1972–73. Committees were restructured to more closely conform to the national auxiliary committees. A committee to assist physicians' widows was created. The Howard County Auxiliary was organized. National recognition was again received for Maryland's AMA-ERF contributions.

Donna Miles (Mrs. Leslie) 1973–74. The Maryland auxiliary's twenty-fifth year was a happy and rewarding one. There were more AMA-ERF awards, and counties continued their many and varied health related activities. The auxiliary's annual meeting was highlighted by the presentation of an auxiliary seal and a silver tray from the Med Chi Faculty. A twenty-fifth anniversary charm of sterling silver was made from the auxiliary seal and sold to benefit ERF.

Gerald R. Ford became president of the United States, following the resignation of Richard Nixon.

Betty Robinson (Mrs. John) 1974–75. An auxiliary office in the Med Chi building was made possible through the generosity of the auxiliary president. Bylaws were revised, and the word "Womens" was dropped from the official name.

Barbara Mayle (Mrs. Francis) 1975–76. *Medicine in Maryland* was written especially for the auxiliary by Ruth Fox Hume in observance of the nation's bicentennial. Proceeds from the book went to AMA-ERF. The auxiliary president was invited to attend Med Chi council meetings as a guest/observer.

Auxiliary

Helen Boyer (Mrs. M. McKendree) 1976–77. The number of delegates from the counties to the State House of Delegates was increased. A presidents-elect luncheon for the component chapters was initiated at the annual meeting. The bylaws and the *Handbook* were revised. The past president's pin was redesigned to more closely duplicate the map of Maryland. A lecture fund was established for auxiliary use.

Jimmy Carter was elected president of the United States.

Carol Broaddus (Mrs. Robert) 1977–78. Auxiliary programs and projects continued to expand. Cardiopulmonary resuscitation (CPR) instruction and immunization education were encouraged. A Charles County auxiliary chapter was organized. An auxiliary member participated in Med Chi's Impaired Physician Program.

Kassie Herbert (Mrs. Thomas) 1978–79. CPR programs flourished. Immunization education continued, as did participation in the Impaired Physician Program. Maryland won the Eastern Region ERF award from the national office. The auxiliary cosponsored an open house fund-raiser to display the Med Chi Library's treasures. Legislation was stressed, and auxiliary members listened to lectures on the ABCs of HSAs (health systems agencies), PSROs (professional standards review organizations), HSCRCs (health systems cost review commissions), etc.

Mary Strauss (Mrs. Albert J.) 1979–80. Teenage alcohol was one of the auxiliary's chief concerns. The auxiliary wrote the governor, submitted a comprehensive survey to appropriate legislators, and testified before the House Judiciary Committee. The passage of a bill to raise the legal drinking age was supported. The National Shape-Up For Life campaign was launched. Again, the auxiliary won national ERF awards.

Mary Skipton (Mrs. R. Kennedy) 1980–81. In keeping with the theme, "Better Health for the Family," nutrition and exercise were emphasized. There were health fairs and family assistance programs. Auxilians participated in the Lady Equitable Race for joggers, runners, and walkers to continue the Shape-Up For Life program.

President Ronald Reagan was inaugurated in January 1981.

Jackie Chang (Mrs. Paul) 1981–82. There were updates on cosmetic and reconstructive surgery, phobias and their treatment, and drug abuse among children. Health Careers Day attracted 368 high school juniors. In recognition of auxiliary work, Governor Hughes invited the auxiliary's legislative chairperson to the signing of the bill raising the drinking age. The auxiliary received national awards for increased membership, two awards for ERF contributions, and one for the highest per capita ERF contribution in the country.

Virginia Levickas (Mrs. Herbert) 1982–83. A booklet about the auxiliary's board members, *Getting to Know You*, was published. The Lady Equitable Race, the Quiet Raffle, and the State Board Christmas Sharing Card all benefited AMA-ERF. The *Handbook* was revised and updated. Membership increased to almost 1,400 through dual billing with Med Chi.

Bobbie Niklewski (Mrs. Edmund) 1983–84. During the auxiliary's thirty-fifth year, there were over 1,300 members. The first Mid-Atlantic Conference on the Prevention of Child Abuse was attended by sixty auxiliaries from Maryland, Virginia, West Virginia, the District of Columbia, and New Jersey. The Maryland auxiliary joined a coalition of health organizations—The Healthy Majority—to urge passage of legislation to limit smoking in public buildings. An auxiliary, Helen Boyer from Montgomery County, became the first woman and first nonphysician to be elected chairperson of the Maryland Medical Political Action Committee (MMPAC). The Southern Medical Association held its annual meeting in Baltimore.

Mildred Taylor (Mrs. Charles) 1984–85. Communication was the auxiliary's focal point, and the auxiliary conveyed information on the Shape-Up For Life program and the problems of fetal alcohol syndrome (FAS). The Delaware State Association auxiliary was informally adopted by the Maryland Auxiliary until the Delaware chapter could become a fully functioning unit again. A gift of \$15,000, to be paid over three years, was pledged to the Med Chi Building Fund. The third-year donation also purchased a display case, which is in the hallway outside Osler Hall.

The Great Communicator—Ronald Reagan—was re-elected president of the United States.

Kathy Karpers (Mrs. Bernard) 1985–86. "Don't Retire From Life—Share the Experience of a Lifetime" was the theme addressed throughout the year. The professional liability issue was on the minds of all auxiliary members. The auxiliary worked with MMPAC on voter registration. There were health careers days, and scholarships were awarded in the counties. Maryland was one of two states in the country to achieve 100 percent participation in AMA-ERF. A Frederick County auxiliary chapter was organized.

Jack Sargeant, executive director of Med Chi for 28 years, died in November 1985.

Nancy Howell (Mrs. Daniel) 1986–87. Emphasis was put on improving and updating the relationship between the medical societies and their auxiliaries, both the state and county chapters. An attempt was made to assess the non-auxilians—those who could join the auxiliary but did not. Committees functioned productively and meetings were well attended. Awards continued to be received for Maryland's support of

Auxiliary

AMA-ERF. After 38 years, one of Maryland's own was designated president-elect of the American Medical Association Auxiliary—Mary Strauss of Washington County. For the next two years, this truly did become *Mary's land*.

Angelo Troisi, FACHE became executive director of Med Chi.

Ching Barretto (Mrs. Alberto) 1987–88. Programs and projects were very productive. Over \$35,000 was raised for AMA-ERF, making this a banner year. Maryland won a grand prize for Harford County's Medical Heritage exhibit at the Southern Medical Auxiliary Association's (SMAA) convention. This exhibit was on the life of Dr. John Archer, the first medical school graduate on this continent, and included his original diploma. "Mary's Committee" was created to prepare for the incoming national president's year.

Eva Edmonds (Mrs. Craig) 1988–89. During the auxiliary's fortieth year, the Organ Annie program was promoted throughout the state. The convention program and annual reports were consolidated into one book. Mary Strauss was installed as the first AMA auxiliary president from Maryland. More than twenty-five auxiliaries went to Chicago to witness the ceremony. Maryland won second place for per capita donations to AMA-ERF. Mary Strauss was elected an honorary member of the state auxiliary.

As Mary Strauss' year as president of the AMA Auxiliary came to a close, Maryland auxiliaries donned black skirts, yellow blazers, and black-eyed-susan corsages, and served as pages at the annual convention in Chicago. Maryland auxiliaries were highly visible and heard comments such as "walking through the yellow pages" and the "yellow jackets." It was a fun year.

George Bush became the 41st president of the country.

Victoria Cameron (Mrs. Ronald) 1989–90. The prevention of child abuse was emphasized. The auxiliary supported the Chesapeake Institute in furthering its state-wide assistance to abused children. Legislation was also a focal point. The Legislative Day in Annapolis during the 1990 session was well attended. One of the year's highlights was the organization of the Kent County Auxiliary.

Josie Figueroa (Mrs. Augusto) 1990–91. "Teamwork for a Better Image" was the theme. An auxiliary fact sheet describing who the members of the auxiliary are, what the auxiliary does, and the benefits of membership was developed and

distributed. Federated membership was promoted. Washington County's Elder Love program was featured in the AMA auxiliary's publication *Facets*. Maryland's entry in the SMAA Medical Heritage category won second place. For the first time, an auxiliary—Dr. Reynaldo Lee-Llacer—was elected president of Med Chi. The auxiliary president's photograph and biography were included in the presidential reception program—this, too, was a first.

Vivian Lynn (Mrs. John) 1991–92. Breast cancer awareness was promoted throughout the year, including the importance of breast self-examination and mammography for early detection. The Reach for Recovery program was featured. A day of free screening at the University of Maryland Mammogram Van was made available to deserving women. Med Chi's Physician Rehabilitation Committee explained to auxiliary members the services provided to impaired physicians and their families. Financial support was given to the hospice program of Prince George's County.

This compilation is but a capsule of the activities, programs, and progress of the state auxiliary's history. The auxiliary has been recognized for its philanthropic contributions; over \$600,000 has been raised by the components and state auxiliary for AMA-ERF and this amount has been distributed to Maryland medical schools. Outstanding programs in medical education and community service have been provided. At present, there are over 1,300 members from the thirteen component auxiliaries.

Over the past forty-three years, many changes have taken place. There are now male members; the faculty is aware of the auxiliary's vast wealth of ability, energy, and resourcefulness; and auxiliary members now serve on numerous Med Chi committees.

Though the auxiliary's goals may have varied over the years, the goals have remained basically the same—to promote health-related educational and charitable endeavors through volunteerism, and to help create better life for all. The Auxiliary to the Medical and Chirurgical Faculty of Maryland is proud of its history, its goals, and its accomplishments.

To the auxiliary's past presidents, we honor and salute you for leading and guiding us so capably from 1949 to 1992, for you have been instrumental in creating and establishing our annals. We thank you. We trust the next forty-three years will be as enriching and fulfilling as the first.

HELEN BOYER (Mrs. M. McKendree) ■

Board of Physician Quality Assurance Actions

In the matter of Jose M. Hipolito, M.D. before the Maryland Board of Physician Quality Assurance

Consent order of reprimand and order reinstating license

On July 31, 1991, the State Board of Physician Quality Assurance (the board), pursuant to its authority under *Md. Health Occ. Code Ann.* §14-601 and §14-602, issued Jose M. Hipolito, M.D. (the respondent), a cease and desist letter, incorporated herein as Exhibit A. On August 1, 1990, Jose M. Hipolito, M.D., signed a consent agreement to cease and desist from the practice of medicine, agreeing to not practice medicine until his license has been reinstated by the board. This consent agreement is incorporated herein as Exhibit B.

On August 14, 1991, a case resolution conference was held. Present were J. Andrew Sumner, M.D., acting board settlement officer and board member; Frank A. Gunther, Jr., board member; Peter E. Dans, M.D., board member; John T. Lynn, M.D., board member; Barbara Hull Foster, board counsel; Darlene A. Fleischmann, Esquire, chief of compliance division; Stephen H. Johnson, Esquire, chief case manager; Jose M. Hipolito, M.D., respondent; and Brad Hallwig, Esquire, attorney for respondent. As a result of negotiations entered into during the case resolution conference, respondent agreed to this consent order of reprimand and order reinstating license.

Findings of fact

1. On February 9, 1973, respondent was licensed to practice medicine in the state of Maryland and remained licensed until September 30, 1990.
2. Persons whose last names started with the letters "A" through "L" had to submit renewal applications to the board by September 30, 1990 in order to be validly renewed. The board did not receive a renewal application from the respondent by September 30, 1990, therefore the respondent was not authorized to practice medicine in Maryland after that date.
3. On or about December 1, 1990, the respondent's status in the database maintained by the Department of Health and Mental Hygiene Boards and Commissions Rosters and Renewal Unit changed to "N," indicating nonrenewal.
4. In late January 1991, Bon Secours Hospital requested that the respondent submit documentation of his Maryland licensure renewal as part of his application for renewal of his hospital privileges.
5. On or about January 1991, respondent submitted a renewal certificate altered to indicate current licensure in support of his application for renewal of privileges at Bon Secours.
6. The respondent continued to practice medicine, in an

uninterrupted fashion, and maintained an office for the practice of medicine at 4209 Frederick Avenue, Baltimore.

7. On June 18, 1991, the board received information that respondent had submitted invoices for services rendered at the Payson Street Clinic, P.A. to the Maryland Medicaid Program. These claims had been denied, as respondent was listed as non-renewed in 1990 by the board.
8. On July 10, 1991, respondent was visited by staff members from the board. Respondent was informed that it was necessary for him to submit documentation of his renewal to the board. Respondent was informed that this documentation needed to be received at the board by Friday, July 12, 1991. The information was not received by Friday, July 12, 1991.
9. On July 18, 1991, respondent telephoned the board to state that his disbursement records indicated a renewal payment to the board, but he was unable to locate the canceled check; the bank statement did not indicate payment on the check.
10. On July 22, 1991, a letter was hand delivered to the respondent stating that all documentation regarding respondent's license status be delivered to the board by 4:30 p.m., on July 25, 1991.
11. On July 25, 1991, respondent appeared at the board with a letter of explanation. Respondent stated in his letter that having been requested by Bon Secours Hospital to supply a copy of his current renewal certificate, he had made an extensive search for the license but had been unable to find it. Respondent then admitted to having altered the old certificate so that it would appear to be current and valid. Respondent submitted this altered copy to Bon Secours Hospital. Respondent believed at this time that he had received the new license but had misplaced it. While at the board offices, respondent demonstrated to board staff the manner in which he stated he had altered his old license.
12. At its meeting of December 11, 1991, the board considered the consent order of reprimand and order reinstating licensure in conjunction with the respondent's application for reinstatement of licensure.

Conclusions of law

Based upon the findings of fact, the board concludes, as a matter of law that:

1. The respondent practiced medicine without a license from October 1, 1990 until August 1, 1991 in violation of *Md. Health Occ. Code Ann.* Sections 14-601 and 14-602;
2. Practicing without a license is unprofessional conduct in the practice of medicine and is grounds under *Md. Health Occ. Code Ann.* Section 14-404(a)(3) for disciplinary action and for denial of reinstatement under Section 14-205(a)(iii);

Board of Physician Quality Assurance Actions

3. The failure to determine if one is properly licensed when circumstances would give a reasonable person doubt as to whether one is properly licensed is unprofessional conduct in the practice of medicine, and is grounds for disciplinary action under Section 14-404(a)(3) and for denial of reinstatement under Section 14-205(a)(iii);
4. The alteration of a renewal certificate and submission of that certificate to hospital credentialing authorities is unprofessional conduct in the practice of medicine and is grounds for disciplinary action under *Md. Health Occ. Code Ann.* Section 14-404(A)(3) and for denial of reinstatement under Section 14-205(a)(iii);
5. The alteration of a renewal certificate and submission of that certificate to hospital credentialing authorities is making or filing a false report in the practice of medicine, and is grounds for discipline under *Md. Health Code Ann.* Section 14-404(A)(11) and for denial of reinstatement under Section 14-205(a)(iii).

Order

Based on the foregoing findings of fact, it is this 17th day of December 1991, by an affirmative vote of the majority of the full authorized membership of those members of the Board of Physician Quality Assurance of Maryland who considered this case,

ORDERED, that the board shall promptly reinstate respondent's license to practice medicine in the state of Maryland in accordance with the normal procedures for the reinstatement of licensees, subject to the following conditions precedent:

1. Respondent shall pay to the Payson Street Clinic, P.A., the amount of \$2,500.00.
2. Respondent shall submit proof to the board that the fine has been paid to Payson Street Clinic, and be it further

ORDERED, that the respondent is hereby formally **REPRIMANDED**, and be it further

ORDERED, that this is a final order and as such is considered a public document pursuant to the Maryland Public Information Article, State Government Article, *Annotated Code of Maryland*, §10-611 *et seq.* specifically §10-617(h)(2)(vi).

ISRAEL H. WEINER, M.D., Chairperson
Maryland Board of Physician Quality Assurance

Consent

By signing this consent, I hereby accept and agree to be bound by the foregoing consent order and its conditions and restrictions, consisting of four pages.

1. I admit to the truth of the findings of fact and agree with the conclusions of law set forth herein.
2. I acknowledge the validity of this order as if made after a hearing in which I would have had the right to confront witnesses, to give testimony, to call witnesses on my

behalf, and to all other substantive and procedural protections provided by law.

3. I also recognize that I am waiving my right to appeal any adverse ruling by the board that might have followed any such hearing. By this consent I waive all such rights.
4. I understand that if I fail to comply with any of the conditions of probation enumerated above, the board, after notification, a hearing, and a determination of violation, may impose any additional disciplinary sanctions it deems appropriate.
5. I have had an opportunity to review this order. I voluntarily sign this order understanding its meaning and effect.

JOSE M. HIPOLITO, M.D.

Exhibit A

July 31, 1991

Dear Dr. Hipolito:

It has come to the attention of the Board of Physician Quality Assurance (the board) that you are practicing medicine without a license. The board's records indicate you did not renew your license by September 30, 1990 as is required by law. Thus you are unlicensed. The information received indicated that while unlicensed to practice medicine in Maryland, you have maintained an office at 4209 Frederick Avenue in Baltimore and have maintained current privileges at Bon Secours Hospital. Furthermore, you signed, on several occasions, forms for Medicaid reimbursement for treatment provided since September 30, 1990. Finally, the board has received information that you submitted to Bon Secours an altered renewal certificate indicating that you were currently licensed through September 30, 1992.

Having received information indicating that you were presenting a license renewal certificate showing that you were currently licensed, the board attempted to confirm through investigation the current status of your license. On July 10, 1991, you were advised by board staff to submit documentation that you had renewed your license in 1990. On July 18, 1991, you telephoned Stephen Johnson of the board staff and told him that, although your disbursement records indicated a renewal payment to the board, you were unable to locate the canceled check and your bank statements did not indicate payment on the check in question. You also stated that you had submitted a renewal certificate previously issued to you to Bon Secours after altering the date of expiration to indicate that you were licensed through September 30, 1992. Mr. Johnson asked that you continue searching for documentation regarding your licensure and to write a letter to the board stating what documentation you were unable to find and fully explaining your submission of an altered certificate to Bon Secours. On July 22, 1991, Mr. Johnson hand delivered a letter to your office at 4209 Frederick Avenue advising you that all documentation regarding your license status would need to be provided to the board by 4:30 p.m. on July 25, 1991.

On July 25, 1991, you appeared at the board offices at 4201 Patterson Avenue. You presented a letter to the board in which you provide the following explanation of the above circumstances:

About the later part of January, Bon Secours Hospital informed me to submit a copy of the licence (sic) for renewal of hospital privileges. I looked for the new licence all over the place but did not find it. I was fully convinced that I received the new licence (sic) before December 1990 and

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through my own fault misplaced it. As the deadline for submission drew near I got the old licence (sic) and altered the expiration date, copied it and submitted it to Bon Secours Hospital. A foolish act of desperation and convenience at the time. I really believe that I have the 1990 renewal license in my possession and due to my carelessness misfiled the license.

While present at the board offices you also demonstrated the manner in which you altered the renewal certificate.

Since you are unlicensed, the board orders you to immediately CEASE AND DESIST from the practice of medicine in Maryland and from representing that you are authorized to practice medicine in Maryland.

Practicing medicine in Maryland without a license violated HO §14-601, which states

Except as otherwise provided in this title, a person may not practice, attempt to practice, or offer to practice medicine in this state unless licensed by the board.

These acts are also in violation of HO §14-602 which states

- (a) Unless authorized to practice medicine under this title, a person may not represent to the public, by description of services, methods, or procedures, or otherwise, that the person is authorized to practice medicine in this state.
- (b) Except as otherwise provided in this article, a person may not use the words or terms "Dr.," "doctor," "physician," "D.O.," or "M.D." with the intent to represent that the person practices medicine, unless the person is
 - (1) Licensed to practice medicine under this title;
 - (2) A physician licensed by and residing in another jurisdiction, while engaging in consultation with a physician licensed in this state;
 - (3) A physician employed by the federal government while performing duties incident to that employment;
 - (4) A physician who resides in and is licensed to practice medicine by any state adjoining this state and whose practice extends into this state; or
 - (5) An individual in a postgraduate medical program that is approved by the board.

You should be aware that under Section 14-607 of the act that a person who violates either Section 14-601 or 14-602 may be found guilty of a misdemeanor and on conviction can be subject to a fine not exceeding \$5,000 or imprisonment not exceeding five years or both.

As previously stated, the board has voted, through its weekly review panel, to order you to immediately CEASE AND DESIST from the practice of medicine and from representing that you are authorized to practice medicine in Maryland. Further, the board requires that you sign and return the attached consent agreement within five working days upon the receipt of this letter. An extra copy of this letter is enclosed for you to sign and return. Failure to comply with the board's order may result in this case being referred to the state's attorney's office for prosecution.

If you dispute the allegations contained herein, you should advise the board in writing within five working days upon receipt of this letter. If you wish to apply for reinstatement, please contact Ms. Maxine Miles of the board at 764-4763. You should be aware that reinstatement is subject to board approval, which is not automatic, and that an applicant for reinstatement may not practice medicine while the application is pending. You should be aware that the board periodically holds case resolution conferences (CRCs) to attempt to resolve pending cases. Attendance at a CRC meeting may be helpful

in expediting the resolution of your reinstatement application, if you choose to make such an application. A CRC has been scheduled for August 14, 1991 at 1:00 p.m. If you wish to attend that meeting, please contact Ms. Heather McLaughlin Johnson at 764-4783.

ISRAEL H. WEINER, M.D., Chairperson
Maryland Board of Physician Quality Assurance

Exhibit B

Consent agreement to cease and desist

Having been informed by the Maryland Board of Physician Quality Assurance (the board) by a letter dated July 31, 1991, that persons not currently licensed by the board may not practice medicine in Maryland nor represent themselves as being authorized to practice medicine in Maryland, and having been informed that the board has reason to believe that I, Jose Martin Hipolito, have practiced medicine in Maryland after the lapse of my license on September 30, 1990, I hereby agree to CEASE AND DESIST from practicing medicine as defined in *Maryland Health Occupations Code Annotated* §14-101(j), and from representing that I am authorized to practice medicine in Maryland until such time as my license has been reinstated by the board.

JOSE MARTIN HIPOLITO, M.D.

■ ■ ■

**In the matter of
Yoginder Kumar, M.D.
before the
Maryland Board of
Physician Quality Assurance
Final order**

Based on information received by the Board of Physician Quality Assurance of the State of Maryland (the board), the board charged YOGINDER KUMAR, M.D. (respondent) on July 23, 1991 under the Maryland Medical Practice Act (the act), *Md. Health Occ. Code Ann.* Section 14-401 *et seq.*

The pertinent provisions of the act are as follows:

Section 14-404. Denials, reprimands, probations, suspensions and revocations—Grounds.

- (a) *In general.* Subject to the hearing provisions of Section 14-405 of this subtitle, the board, on the affirmative vote of a majority of its full authorized membership, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:

- (21) Is disciplined by a licensing or disciplinary authority or convicted or disciplined by a court of any state or country or disciplined by any branch of the United States uniformed services or the Veterans Administration for an act that would be grounds for disciplinary action under this section;

The grounds underlying the charges of this section are that respondent

- (1) Fraudulently or deceptively obtains or attempts to obtain a license for the applicant or licensee or for another; and

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- (3) Is guilty of immoral or unprofessional conduct in the practice of medicine.

The board notified respondent that if respondent did not request a hearing, the board would issue this final order.

Based on clear and convincing evidence, the board, on the affirmative vote of a majority of its full authorized membership considering this case, issues this final order.

On November 13, 1991, a case resolution conference of the board (the conference) was held. Attending the conference were C. Frederick Ryland, assistant attorney general, counsel to the board; and Pamela J. LoPreto, Compliance Division. As a result of the conference, the respondent and the board agreed to enter into the following order, which includes findings of fact, conclusions of law, and a final order.

Findings of fact

1. At all times relevant to these charges, the respondent was and is licensed to practice medicine in the state of Maryland;
2. The Federation of State Medical Boards was informed by the Illinois Department of Professional Regulation that respondent had entered into a consent order and been reprimanded on January 5, 1990 for the following reasons:

Information came to the attention of the Illinois board that respondent did not possess an Illinois controlled substance license, as he practiced in a federal hospital. During a 2-3 month period of time, respondent opened a private practice and wrote a few controlled substance prescriptions. For this offense, he was officially reprimanded and a fine of \$1,000.00 was imposed.

3. On or before August 17, 1990, respondent submitted an application for renewal of his license to practice medicine in Maryland, in which respondent answered the following question incorrectly:

"Has any state licensing or disciplinary board or a comparable body in the armed services denied your application for licensure, reinstatement, or renewal; or taken any action against your license, including but not limited to reprimand, suspension, or revocation?"

Respondent's answers were false because on January 5, 1990, respondent was reprimanded by Illinois.

Unaware of respondent's false answers, the Maryland State Board of Physician Quality Assurance renewed respondent's license to practice medicine in Maryland on or before September 30, 1990.

4. Prescribing controlled substances without a controlled substance license is unprofessional conduct in the practice of medicine.
5. A reprimand and fine by the Department of Professional Regulation of the State of Illinois is being disciplined by a licensing or disciplinary authority.
6. Incorrectly completing the 1990 renewal application is fraudulently or deceptively obtaining or attempting to obtain a license.
7. Incorrectly completing the 1990 renewal application is unprofessional conduct in the practice of medicine.

Conclusions of law

Respondent committed the following prohibited acts:

1. Respondent was

Disciplined by a licensing or disciplinary authority or convicted or disciplined by a court of any state or country or disciplined by any branch of the United States uniformed services or the Veterans Administration for an act that would be grounds for disciplinary action under this section, *Md. Health Occ. Code Ann.* Section 14-404 (a) (21);

2. The underlying grounds for this disciplinary action were that respondent

Fraudulently or deceptively obtains or attempts to obtain a license for the applicant or licensee or for another, *Md. Health Occ. Code Ann.* Section 14-404 (a) (1) (1991); and

Is guilty of ... unprofessional conduct in the practice of medicine, *Md. Health Occ. Code Ann.* Section 14-404 (a) (1991).

Order

It is this 4th day of February 1992, by an affirmative vote of a majority of the full authorized membership of those members of the board who considered this case,

ORDERED, that respondent is REPRIMANDED; and be it further

ORDERED, that this is a final order and as such will be considered a public document pursuant to *Md. State Gov't Code Ann.* Section 10-611 *et seq* (1989 Cum. Supp.)

ISRAEL H. WEINER, M.D., Chairperson
Maryland Board of Physician Quality Assurance

Consent

By this consent, I hereby admit to the findings of fact contained in this order. I hereby agree to be bound by the foregoing final order and its conditions and restrictions.

I am entering into this final order for the purpose of resolving the charges initiated by the Board of Physician Quality Assurance against my license to practice medicine as defined in the findings of fact and conclusions of law.

I acknowledge the validity of this order and the legal authority of the Board of Physician Quality Assurance to issue and enforce this order.

I hereby waive any right to appeal this matter under §14-408 of the Health Occupations Article, *Annotated Code of Maryland*.

I understand that if I fail to abide by the conditions of this order, I may suffer disciplinary action against my license to practice medicine in the state of Maryland.

I sign and consent to this order after having an opportunity to consult with my counsel and with full understanding of the meaning and terms of the order.

YOGINDER KUMAR, M.D.
GERALD B. SALTZBERG, ESQUIRE

Board of Physician Quality Assurance Actions

In the matter of
Richard C. Matzkin, M.D.
before the
Maryland Board of
Physician Quality Assurance

Order for summary suspension of license to practice medicine

The State Board of Physician Quality Assurance (the board) herein sets forth the following background information as pertinent to this order for summary suspension (the order) with regard to the license of Richard C. Matzkin, M.D. (the respondent) to practice medicine in the state of Maryland.

1. The respondent is a physician licensed to practice medicine in the state of Maryland.
2. The respondent has been licensed in Maryland since 1981.
3. Until January 30, 1992, the respondent was practicing at Garrett County Memorial Hospital as an emergency room physician.
4. The respondent has no other hospital privileges in Maryland.
5. The Board's determination to summarily suspend the respondent's license is based upon the following information:
 - a. The respondent possessed a license to practice medicine from the state of Virginia, which he surrendered to the Virginia Board of Medicine through a consent order dated June 25, 1991.
 - b. On January 30, 1992, the respondent's locum tenens privileges at Garrett County Memorial Hospital were suspended.
 - c. On January 30, 1992, the respondent was arrested in Montgomery County, Maryland and was charged with two counts of prescribing controlled dangerous substances, not in the course of his regular professional duties and not in conformance with the standards of the medical profession and not in conformance with the provisions of the Maryland Controlled Dangerous Substance Act, in violation of Article 27, §288 (c) of the *Annotated Code of Maryland*.
6. The board's determination to summarily suspend the respondent's license is also based upon the following additional information:
 - a. On November 27, 1991, the board voted to charge the respondent with a violation of §14-404(a)(24).
 - b. The respondent acknowledged receipt of the charges under §14-404(a)(24) and requested a hearing, through his counsel, on January 17, 1992. A hearing on those charges has not been scheduled as of February 17, 1992.
 - c. The November 27, 1991 charges against the respondent were based upon charges against the respondent in the state of Virginia and the findings of fact contained within the June 25, 1991 Virginia consent order.

d. The findings of fact from the Virginia Board of Medicine's June 25, 1991 consent order include the following:

1. On diverse occasions between March 14, 1988 through May 4, 1990, Dr. Matzkin inappropriately prescribed controlled substances to Individual A, a person for whom he maintains no medical records, 540 dosage units of Percocet (oxycodone and acetaminophen) tablets and 40 dosage units of Tylox (oxycodone and acetaminophen) capsules, Schedule II controlled substances of high abuse potential, outside of a bona fide physician/patient relationship. Further, by his own admission, Dr. Matzkin did not examine the individual prior to prescribing said drugs and Dr. Matzkin routinely picked up the filled prescriptions which he mailed to Individual A at his residence in the state of Maryland.
2. On diverse occasions between May 31, 1988 through June 15, 1989, Dr. Matzkin inappropriately prescribed to Individual B, a person for whom he maintains no medical records, 180 dosage units of Percocet tablets, a Schedule II controlled substance of high abuse potential, outside of a bona fide physician/patient relationship. Further, by his own admission, Dr. Matzkin did not examine the individual prior to prescribing said drugs and he routinely picked up the filled prescriptions which he mailed to Individual B at her residence in the state of Maryland.
3. On diverse occasions between March 1, 1989 through May 13, 1990, Dr. Matzkin inappropriately prescribed to Individual C, a person for whom he maintains no medical records, various controlled substances of high abuse potential, outside of a bona fide physician/patient relationship, to wit: 120 dosage units of Darvocet-N 100 (propoxyphene napsylate and acetaminophen) capsules (Schedule IV), 360 dosage units of Acetaminophen #4 (with codeine) 60 mg tablets (Schedule III), and 30 dosage units of Bancaps HC (Hydrocodone bitartrate, Schedule III). Further, by his own admission, Dr. Matzkin did not examine the individual prior to prescribing said drugs and he routinely picked up the filled prescriptions which he mailed to Individual C, or carried to said individual when he visited him at his residence in the state of Maryland.
4. On December 29, 1989 and January 31, 1990, Dr. Matzkin inappropriately prescribed to Individual D, a person for whom he maintains no medical records, 60 dosage units of Tylox and 50 dosage units of Percocet, Schedule II controlled substances of high abuse potential, outside of a bona fide physician/patient relationship and contrary to

Board of Physician Quality Assurance Actions

sound medical judgment. Further, by his own admission, Dr. Matzkin did not examine the individual prior to prescribing said drugs and he routinely picked up the filled prescriptions which he mailed to Individual D at his residence in the state of Maryland.

5. On May 26, 1988, Dr. Matzkin prescribed to Individual E, a person known to him to be drug dependent and a person for whom he maintains no medical records, 40 dosage units of Percocet, a Schedule II controlled substance of high abuse potential. Again, on February 15, March 23, May 17, 1989 and January 21, 1990, Dr. Matzkin prescribed to Individual E, 95 dosage units of Valium (diazepam) 5 mg tablets, a Schedule IV controlled substance of high abuse potential, without accepted therapeutic purpose, contrary to sound medical judgment, and outside of a bona fide physician/patient relationship. Also, on January 31, 1990, Dr. Matzkin prescribed to Individual E, 5 dosage units of Dilaudid (hydromorphone hydrochloride) 4 mg tablets, a Schedule II controlled substance of high abuse potential. By his own admission, Dr. Matzkin did not examine the individual prior to prescribing said drugs and he routinely called in prescriptions to a local pharmacy in Florida, or picked up the filled prescriptions which he mailed to Individual E at her residence in the state of Florida.
6. On January 3, January 11, January 29, February 9, March 14, and May 24, 1990, Dr. Matzkin inappropriately prescribed to Individual F, a person for whom he maintains no medical records, 220 dosage units of Acetaminophen #4, and on January 11, 1990, 30 dosage units of Fastin 30 mg capsules. Said prescribing was contrary to sound medical judgment and outside of a bona fide physician/patient relationship.
- e. Based upon the findings of fact cited above, the Virginia Board of Medicine issued the June 25, 1991 order which permitted the voluntary surrender of the license of Richard C. Matzkin, M.D. to practice medicine in Virginia in lieu of further administrative proceedings.
7. The respondent is presently released on personal bond from the District Court of Maryland for Montgomery County.
8. The respondent's retention of a license to practice medicine in Maryland, in light of his recent arrest and the findings of fact cited by the Virginia Board of Medicine, pose a grave risk and imminent danger to public health, safety, and welfare of citizens of the state of Maryland.
9. On February 21, 1992, the respondent was notified of the

board's proposed decision to summarily suspend his license and was given an opportunity to appear at the board meeting of February 26, 1992 to show cause why the board should not execute the order for summary suspension. The respondent was further notified that he may appear at the board meeting of February 26, 1992 regarding the order for summary suspension through counsel, if he so chooses, or in person with counsel.

10. Based upon the above information, the board has reason to believe that the respondent has violated *Maryland Health Occupations Code Annotated* §14-404(a)(3), (4), (8), and (25). The pertinent provisions of §14-404(a) provide:

- (a) Subject to the hearing provisions of §14-405 of this subtitle, the board, on the affirmative vote of the majority of its full authorized membership, may reprimand any licensee, place any licensee on probation, or suspend or revoke a licensee if the licensee:
 - (3) Is guilty of immoral conduct in the practice of medicine;
 - (4) Is professionally, physically, or mentally incompetent;
 - (8) Is addicted to, or habitually abuses, any narcotic or controlled dangerous substance as defined in Article 27 of the *Code*; and
- (25) Was subject to investigation or disciplinary action by a licensing or disciplinary authority or by a court of any state or country for an act that would be grounds for disciplinary action under this section and the licensee:
 - (i) surrendered the license issued by the state or country to the state or country.

Conclusions of law

Based upon the foregoing facts, the board finds that the public health, safety, and welfare imperatively require emergency action in this case, pursuant to *Md. State Gov't. Code Ann.* §10-405 (b) (1984).

Order

It is this 26th day of February 1992 by the State Board of Physician Quality Assurance

ORDERED, that pursuant to the authority vested in the board by *Md. State Gov't. Code Ann.* §10-405(b) (1984), respondent's license to practice medicine in the state of Maryland is hereby SUMMARILY SUSPENDED; and be it further

ORDERED, that, upon request by respondent, a hearing to consider this summary suspension will be held at the Office of Administrative Hearings, Administrative Law Building, Greenspring Station, 10753 Falls Road, Lutherville, Maryland 21093, within thirty days of the respondent's request for a hearing; and be it further

ORDERED, that on presentation of this order, respondent shall surrender to the board's investigator the following items:

- (1) his original Maryland license from the Board of Medical Examiners;
- (2) the renewal card of his license to practice medicine from the Board of Physician Quality Assurance;

Board of Physician Quality Assurance Actions

- (4) Maryland Controlled Dangerous Substances Registration Certificate Number M20315;
- (5) all controlled dangerous substances;
- (6) all Medical Assistance prescription forms; and
- (7) any prescription pads on which his name and DEA number are imprinted; and be it further

ORDERED, that a copy of this order shall be filed with the board in accordance with *Md. Health Occ. Ann.* §14-407 (1991 Repl. Vol.); and be it further

ORDERED, that this order is a public document pursuant to *Md. State Code Ann.* §10-601 *et seq* (1984).

ISRAEL H. WEINER, M.D., Chairperson
Maryland Board of Physician Quality Assurance

■ ■ ■

**In the matter of
Velma E. L. Powell, M.D.
before the
Maryland Board of
Physician Quality Assurance**

Consent order

Findings of fact

1. At all times relevant, the respondent was and is licensed to practice medicine in the state of Maryland.
2. On or about October 12, 1989, the respondent was charged in the matter of *State of Maryland v Velma E. L. Powell*, under case number CA892730X (Circuit Court for Prince George's County) with conspiracy to enable the unauthorized practice of medicine (a violation of Health Occupations Article §14-706) and with knowingly and intentionally prescribing controlled substances outside the course of her professional duties (a violation of Article 27, §288(c)).
3. On April 3, 1990, respondent appeared in the Circuit Court for Prince George's County, Maryland before the Honorable Robert J. Woods. At that time, the respondent, pursuant to a plea agreement with the Office of the Attorney General, entered guilty pleas, under the terms of *North Carolina v Alford*, 400 US 25 (1970), to the following counts: (1) conspiracy to enable the unauthorized practice of medicine and (2) knowingly and intentionally prescribing controlled substances outside the course of a practitioner's professional duties. As to Count 2, respondent agreed to pay a fine in the amount of \$100,000. As to both counts, respondent was sentenced concurrently to supervised probation for a period of five years.

Conclusions of law

Based upon the foregoing findings of fact, the board concludes, as a matter of law, that the respondent is in violation

of *Maryland Health Occupations Code Annotated* §14-404 (21) (1991 Rep. Vol.).

Order

Based upon the foregoing findings of fact and conclusions of law, it is this 7th day of January 1992, by an affirmative vote of the majority of the full authorized membership of those members of the Board of Physician Quality Assurance of Maryland, who considered this case, hereby

ORDERED, that respondent's license to practice medicine in the state of Maryland is **SUSPENDED** for a period of five years beginning July 1, 1991; and it is further

ORDERED, that, on or after July 1, 1992, but not before July 1, 1992, the suspension of respondent's license to practice medicine in the state of Maryland will be **STAYED** subject to the following terms and conditions:

1. Respondent shall submit to a psychiatric evaluation by an independent board-approved psychiatrist who has not been involved in treating the respondent. Respondent shall bear all costs associated therewith as a condition precedent to the stay of the suspension.
2. Respondent shall not return to the practice of medicine until the board-approved psychiatrist certifies to the board and in writing that respondent is mentally fit to return to the practice of medicine.
3. Respondent shall satisfy all continuing medical education credits and any and all other requirements for licensure set forth in the Maryland Medical Practice Act and the board's rules and regulations. Within seven days of receipt of continuing medical education credit hours, respondent shall send a copy of the certificate of attendance to the board, attention: Chief Case Manager.
4. Respondent is presently undergoing psychotherapy with her psychiatrist, David W. Lockwood, M.D., P.A. Respondent shall continue with psychotherapy sessions as recommended by Dr. Lockwood until such time that respondent is released from Dr. Lockwood's care.
5. In the event that respondent terminates therapy prior to discharge by Dr. Lockwood, Dr. Lockwood shall immediately notify the board that respondent has terminated therapy.
6. Dr. Lockwood shall submit monthly reports to the Suburban Maryland Psychiatric Society Peer Review Committee (SMPS PRC), attention: Ann Birk, M.D., indicating only that respondent is attending the therapy sessions as recommended. SMPS PRC shall immediately notify the board in the event that Dr. Lockwood fails to submit monthly reports as required or Dr. Lockwood reports that respondent has failed to attend therapy sessions as recommended.
7. In the event that Dr. Lockwood is unable to continue treatment, through no fault of respondent, Dr. Lockwood must immediately notify SMPS PRC. SMPS PRC, within ten days of receipt of the notice, shall present respondent

Board of Physician Quality Assurance Actions

with a list of three approved psychiatrists from whom respondent must immediately select another therapist. The new therapist must inform SMPS PRC in writing that he/she agrees to perform all duties required under this order.

8. Respondent shall sign a release authorizing Dr. Lockwood and the board-approved psychiatrist to send copies of their reports to the board. Respondent shall sign a release authorizing the board to release the reports to the supervisory physician(s), the peer reviewers, and Dr. Lockwood. The respondent shall receive a copy of these reports.
9. If at the end of the aforementioned five-year period the suspension has not been stayed because respondent has failed to comply with all of the above conditions, respondent's license will terminate automatically, WITHOUT PRIOR NOTICE AND AN OPPORTUNITY FOR A HEARING. Any attempts on respondent's part to thereafter regain her license will require her to comply with the reinstatement provisions set forth in the Maryland Medical Practice Act.

ORDERED, that, following the stay of the suspension, respondent will be placed on probation for that portion of the five-year period then remaining subject to the following terms and conditions:

1. Respondent shall satisfy all continuing medical education credits and any and all other requirements for licensure set forth in the Maryland Medical Practice Act and the board's rules and regulations. Within seven days of receipt of continuing medical education credit hours, respondent shall send a copy of the certificate of attendance to the board, attention: Chief Case Manager.
2. In the event that the US Drug Enforcement Administration and the Maryland Division of Drug Control issue new certificates of registration to the respondent allowing the respondent to resume prescription-writing privileges during the probationary period, respondent shall send to the Division of Drug Control a carbon copy, labeled "carbon copy," of every prescription respondent writes for controlled dangerous substances within seven days of the date respondent writes the prescription during the probationary period.
3. During the probationary period, the board shall review the reports from the Division of Drug Control and may require respondent to explain the circumstances of each controlled dangerous substance prescription to the board's satisfaction.
4. Respondent shall continue in psychotherapy with her current psychiatrist, David W. Lockwood, M.D., P.A., until such time that respondent is released from Dr. Lockwood's care.
5. In the event that respondent terminates therapy prior to discharge by Dr. Lockwood, Dr. Lockwood shall immediately notify the board that respondent has terminated therapy.
6. Dr. Lockwood shall submit monthly reports to the Suburban Maryland Psychiatric Society Peer Review Committee (SMPS PRC), attention: Ann Birk, M.D., indicating only that respondent is attending the therapy sessions as recommended. SMPS PRC shall immediately notify the board in the event that Dr. Lockwood fails to submit monthly reports as required or Dr. Lockwood reports that respondent has failed to attend therapy sessions as recommended.
7. In the event that Dr. Lockwood has reason to believe that respondent is a danger to herself or others, Dr. Lockwood will immediately notify Dr. Birk of SMPS PRC.
8. In the event that Dr. Lockwood is unable to continue treatment, through no fault of respondent, Dr. Lockwood must immediately notify SMPS PRC. SMPS PRC, within ten days of receipt of the notice, shall present respondent with a list of three approved psychiatrists from whom respondent must immediately select another therapist. The new therapist must inform SMPS PRC in writing that he/she agrees to perform all duties required under this order.
9. Prior to resuming the practice of medicine, respondent shall immediately contact Dr. Birk (301-365-4447) for the purpose of arranging weekly supervision sessions under the supervision of one or two of the following psychiatrists as determined by Dr. Birk:
 - (a) Larry Sack, M.D.
3801 Connecticut Avenue, Apt. 228
Washington, DC 20008
(202) 363-6962
 - (b) Edward Kirby, M.D.
2820 Thirty-sixth Place, N.W.
Washington, DC 20007
(202) 337-3227
 - (c) Carol Kleinman, M.D.
5481 Wisconsin Avenue, Suite 106
Chevy Chase, MD 20815
(301) 654-1810
 - (d) Harold Eist, M.D.
5705 Ross Meade Drive
Bethesda, MD 20814
(301) 530-0510
10. Respondent shall meet with at least one of the supervising psychiatrists for at least one hour per week. Respondent is not required to attend more than two hours of supervision per week with the supervising psychiatrists.
10. The selected supervising psychiatrist(s) shall have access to and shall review this order, all previous peer review reports and all psychiatric evaluations of respondent.
11. The supervisory psychiatrist(s) shall meet with respondent individually for weekly supervisory sessions for at least one year following respondent's return to practice. The supervisor(s) will determine how much time each week is needed to review respondent's practice.

Board of Physician Quality Assurance Actions

12. The supervisory psychiatrist(s) will make quarterly written reports regarding respondent's practice of psychiatry to the board, attention: Chief Case Manager.
13. In the event that the supervisory psychiatrist(s) believes that respondent is a danger to her patients or herself, or is not competent to practice psychiatry, or is in violation of this order, the supervisor(s) will immediately notify the board.
14. In the quarterly reports, the supervisor(s) will discuss whether weekly supervisory sessions should be continued. The board must ratify the supervisor(s)' recommendations before any change in supervision becomes effective.
15. Respondent shall pay all costs associated with the weekly supervisory sessions and the quarterly reports. The supervisory psychiatrist(s) will submit a bill to respondent on a monthly basis. If respondent fails to pay the bill in a timely fashion, not to exceed within sixty days, the supervisory psychiatrist(s) will notify the board. Failure to pay all bills within sixty days shall result in a violation of this order.
16. Respondent will be subject to an annual peer review of her practice by the SMPS PRC, administrative costs to be paid by the respondent. The SMPS PRC will submit a report to the board, once each year, on the results of the peer review of respondent's practice. The respondent will receive a copy of the report and must follow any recommendations made by SMPS PRC and endorsed by the board.
17. For purposes of this consent order, the supervisory psychiatrist(s) shall be treated as members of SMPS PRC and shall be immune from civil liability in accordance with HO §14-501 when performing the functions of a medical review committee.
18. Respondent shall not engage in the type of conduct that led to the charges brought against her in *State of Maryland v Velma E. L. Powell*, Case Number CA892730X (Circuit Court for Prince George's County).
19. Respondent shall practice in accordance with the laws governing the practice of medicine in Maryland.
20. Respondent shall be responsible for all costs for the additional training, supervision, and psychiatric therapy that she is to obtain during this probation.

ORDERED, that if respondent violates any of the foregoing conditions of probation, the stay may be lifted and the board, after notification, a hearing, and a determination of violation, may impose any additional disciplinary sanctions it deems appropriate; and be it further

ORDERED, that if respondent presents a danger to the public health, safety, or welfare, the board, WITHOUT PRIOR NOTICE AND AN OPPORTUNITY FOR A HEARING, MAY VACATE THE STAY OF SUSPENSION AND REINSTATE THE SUSPENSION, provided that respondent is given notice of the board's action and an opportunity for a

hearing within thirty days after respondent requests a hearing; and be it further

ORDERED, that on or before January 7, 1992, respondent shall hand deliver to Margaret T. Anzalone, deputy director of the board, at the board's office, 4201 Patterson Avenue, Baltimore, Maryland, the following items, where applicable:

1. original Maryland license from the Board of Medical Examiners;
2. current renewal certificate from the board;
3. wallet-size renewal card from the board;
4. US Drug Enforcement Administration Registration (DEA) Certificate;
5. DEA Form 104 (fully completed and executed with Box 1 checked);
6. Maryland Controlled Dangerous Substances Registration Certificate;
7. all prescription pads on which respondent's name and DEA number are imprinted;
8. all Medicaid prescription forms (DHMH Form 235);
9. all DEA order forms; and be it further

ORDERED, that, three years after the effective date of the order, that being the date on which the board signs the order, respondent may petition the board for termination of probation and reinstatement of her license without any conditions or restrictions. Prior to submitting a petition for reinstatement, respondent must be evaluated by a psychiatrist selected by the board. Respondent shall bear the burden of proving, to the board's satisfaction, that she has complied with all the conditions of this order. NOTHING IN THIS ORDER SHALL BE CONSTRUED AS A PROMISE BY THE BOARD TO REINSTATE RESPONDENT'S LICENSE WITHOUT CONDITIONS; and be it further

ORDERED, that respondent will be responsible for all costs incurred under this consent order; and be it further

ORDERED, that this consent order is considered a public document pursuant to *Maryland State Gov't Ann. §10-611 et seq* (1984).

ISRAEL H. WEINER, M.D., Chairperson
Maryland Board of Physician Quality Assurance

Consent

By signing this consent, I hereby accept and agree to be bound by the foregoing consent order and its conditions and restrictions, consisting of thirteen pages.

1. I acknowledge the validity of this order as if made after a hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by law.
2. I also recognize that I am waiving my right to appeal any adverse ruling of the board that might have followed any such hearing. By this consent I waive all such rights.

Board of Physician Quality Assurance Actions

3. I further understand that if I fail to comply with any of the conditions of probation enumerated above, I may suffer disciplinary action against my license to practice medicine in the state of Maryland.
4. I understand that if I fail to fulfill each and every condition required for a stay of the suspension prior to July 1, 1992, the suspension will remain in effect until such time as such conditions have been satisfied.
5. I understand that if I present a danger to the public health, safety, or welfare, the board may, WITHOUT NOTICE PRIOR TO AN OPPORTUNITY TO BE HEARD, vacate the stay of suspension, reinstate the suspension and reinstitute formal proceedings against my license to practice medicine in Maryland.
6. I have had an opportunity to review this order with an attorney. I voluntarily sign this order understanding its meaning and effect.

VELMA E.L. POWELL, M.D. ■

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**In the matter of
Evadne Sang, M.D.
before the
Maryland Board of
Physician Quality Assurance**

Dear Dr. Weiner and members of the board:

Please be advised that I have decided to surrender my license to practice medicine in the state of Maryland, License Number D24228. I understand that I may not give medical advice or treatment to any individual, with or without compensation, cannot prescribe medications, or otherwise engage in the practice of medicine as it is defined in *Md. Health Occ. Code Ann.* §14-101 (1991 Replacement Volume). In other words, I understand that surrender of my license means that I am in the same position as an unlicensed individual. This decision to surrender my license to practice medicine in the state of Maryland is IRREVOCABLE and PUBLIC.

This letter of surrender shall become a public document and shall become effective immediately upon its acceptance by the Board of Physician Quality Assurance (the board), that date being the date on which the board accepts this letter of surrender.

My decision to surrender my license to practice medicine has been prompted by an investigation of my licensure by the board. This investigation revealed the following:

That on May 4, 1989, in the Superior Court of the District of Columbia, in the matter of *District of Columbia v. Evadne Sang*, under case number DC-1371-89, I pleaded guilty to ten counts of Medicaid Provider Fraud ("obtaining, with the intent to defraud, by means of a false claim, false statement, and a failure to disclose information, payment from the District of Columbia as a District of Columbia Medicaid provider, for an

item and service he knew and had reason to know was not provided as claimed") in violation of District of Columbia Code Section 3-702(b)(2) (1985 Supp.). I was sentenced to a period of incarceration of sixty days, the execution of which was suspended, and was placed on supervised probation for a period of one year, subject to the following conditions of probation; payment of a fine in the amount of \$1,000.00; payment of restitution to the office of Health Care Financing in the amount of \$7,539.00; and payment of \$100.00 in costs to the Crime Victims' Compensation Fund.

The board's investigation resulted in charges under the Maryland Medical Practice Act (the act). Specifically, the board charged me with the commission of a prohibited act under *Maryland Health Occ. Code Ann.* (HO) §14-504(b) (1988 Cum. Supp.). The pertinent provision of the act provides as follows:

(b) Crimes involving moral turpitude,—

- (1) Subject to the Administrative Procedure Act, the board shall order the suspension of a license if the licensee is convicted of or pleads guilty or *nolo contendere* with respect to a crime involving moral turpitude, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside.
- (2) After completion of the appellate process, if the conviction has not been reversed or the plea has not been set aside with respect to a crime involving turpitude, the board shall order the revocation of a license subject to the provisions of §14-505 of this subtitle.

I have decided to surrender my license to practice medicine in the state of Maryland to avoid further prosecution on the aforementioned charges under the act. The basis for the charges against me include the findings of the investigation described above.

I affirm that I do not carry on the practice of medicine in the state of Maryland, and do not have active privileges at any hospital, outpatient surgical facility, nursing home, office, or any other health care facility in the state of Maryland. I further affirm that I do not have a current state of Maryland Controlled Dangerous Substances Registration Certificate, or a current United States Drug Enforcement Administration Registration Certificate to prescribe controlled dangerous substances in the state of Maryland.

I understand that the board will advise the Federation of State Medical Boards and the national Practitioners Data Bank, as required by Senate Bill 99-660, through this letter of surrender, and any response to inquiry, that I have surrendered my license to practice medicine as resolution of the matters pending against me. I also understand that, in the event that I would apply for reinstatement of my license in Maryland, or apply for licensure in any other state of jurisdiction, that this letter of surrender, and all underlying documents, may be released or published by the board to the same extent as a final order which would result from a disciplinary action, under the Public Information Act, *State Gov't. Code Ann.* §10-611 *et seq.*

Board of Physician Quality Assurance Actions

I acknowledge that, on the date the board accepts this letter of surrender, I must present to the board Maryland License D24228, including any renewal certificates and wallet-sized renewal cards.

I affirm that I am currently licensed to practice medicine in the District of Columbia and the Commonwealth of Virginia. I acknowledge that on the date the board accepts this letter of surrender, the board will send a copy of this document to John P. Hopkins, Executive Director, District of Columbia Board of Medicine, 605 G Street, N.W., Room 202, Lower Level, Washington, DC 20001; and Hilary H. Conner, M.D., Executive Director, Virginia Board of Medicine, 1601 Rolling Hills Drive, Richmond, Virginia 23229, respectively.

Finally, I wish to make clear that I have consulted with an attorney before signing this letter **IRREVOCABLY SURRENDERING** my license to practice medicine in the state of Maryland. I understand both the nature of the board's actions and this letter of surrender fully. I make this decision knowingly and voluntarily.

EVADNE SANG, M.D.

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**In the matter of
Sarkis Sarkissian, M.D.
before the
Maryland Board of
Physician Quality Assurance
Supplemental consent order**

On March 4, 1991, the Board of Physician Quality Assurance (the board) executed a consent order which was signed by Sarkis Sarkissian, M.D. (the respondent) on February 28, 1991.

The March 4, 1991 consent order was the result of charges brought against the respondent after the board conducted an investigation and peer reviews of the respondent's gynecological practice in St. Mary's County, Maryland. A condition of the March 4, 1991 consent order was that the respondent's obstetrics practice would be the subject of an expedited peer review focusing on recent cesarean section cases.

In July 1991, the board and the respondent received a final report of the peer reviewers regarding the cesarean section review. After receipt of the peer review report, the respondent, acting through counsel and the assigned administrative prosecutor, appeared before the case resolution conference on September 23, 1991.

At the September 23, 1991 settlement conference, a proposal was made for the resolution of the pending matters before the board. The proposed resolution of this matter was presented to the board at its meeting on October 23, 1991. On an affirmative vote of a majority of its full authorized membership, the board decided to enter into the following consent order.

Findings of fact

1. The respondent has been licensed to practice medicine in the state of Maryland since 1983.
2. The consent order of March 4, 1991 between the board and the respondent shall remain in full force and effect and shall be supplemented by this consent order.
3. The respondent remains bound by the terms and conditions of the March 4, 1991 consent order and further agrees to the terms and conditions of this supplemental consent order.
4. The respondent's cesarean practice was reviewed by two board certified practitioners of obstetrics, John G. Frizzera, M.D. and Eugene R. McNinch, Jr., M.D. Both Drs. McNinch and Frizzera reviewed eighteen recent cesarean sections performed by respondent. The peer review conducted by Drs. Frizzera and McNinch was authorized by the March 4, 1991 consent order.
5. Each of the two peer reviewers felt that the respondent could benefit from attending review courses in current obstetrics management with regard to his cesarean section practice. Each of the two peer reviewers felt that a re-review of the respondent's cesarean practice would be appropriate six months after he completed the additional education requirements on obstetrics management.
6. The peer reviewers both recommended that the respondent be required to obtain written consent from the patients regarding the patient's waiver of vaginal birth after cesarean (VBAC).
7. As a result of the peer review and recommendations of the peer reviewers, the board and the respondent have agreed that the respondent may continue to practice medicine in the state of Maryland pursuant to the March 4, 1991 consent order and this consent order.

It is hereby **ORDERED**, that the respondent's probation as **ORDERED** on March 4, 1991 is hereby supplemented to include the terms of this supplemental consent order; and it is further

ORDERED, that the respondent shall provide all of his obstetric patients with the opportunity to have vaginal birth after cesarean (VBAC) where appropriate. The respondent shall document in the patient's medical records the offer of VBAC to the patient and any relevant response from the patient. The respondent will obtain a written consent from any patient who waives VBAC and place the written consent in the patient's medical record. It is further

ORDERED, that the respondent shall attend at his expense the 33rd Annual Emil Novak Memorial Review Course in Gynecology and Obstetrics from October 14 through October 19, 1991 at the Johns Hopkins Hospital Center. The respondent shall submit written evidence of this attendance at the Emil Novak Memorial Review Course to Valerie A. Shanahan, compliance officer or, in her absence, Margaret T. Anzalone, deputy director of the Board of Physician Quality Assurance, within thirty days of his attendance at the course.

Board of Physician Quality Assurance Actions

During the twelve months immediately following the execution of this consent order, the respondent shall attend six separate sessions of Obstetrics Grand Rounds at the Johns Hopkins University Hospital Center, Baltimore, Maryland at his expense. It is further

ORDERED, that the respondent shall obtain the services of a board certified obstetrician to serve as his supervisory physician for the twelve months immediately following the execution of this supplemental consent order. The respondent shall meet at least biweekly with his approved supervisor to review all surgeries conducted by the respondent and all other cases conducted by the respondent at the selection of the supervisor. The respondent will be responsible for all costs associated with the selection and supervision conducted by his supervisor. The supervisor shall provide to the board reports as to his meeting with and review of the respondent's cases on the following schedule: First report due thirty days after the execution of this consent order, second report due ninety days after the execution of this consent order, third report due 150 days after the execution of this consent order, and following reports due on sixty-day intervals. The respondent shall be responsible for providing copies of the peer review reports, charging documents, March 4, 1991 consent order, and this supplemental consent order to his supervisory physician.

The board will provide the respondent with the name of an approved obstetrician whom the respondent may select as his supervisory physician. The supervisory physician shall be given an opportunity to read all of the materials related to the board's file on the respondent prior to commencing with supervision. In the event that the supervising physician can no longer provide supervision to the respondent during the course of the year, the respondent shall have sixty days in which to obtain a new approved supervisory physician. The board, the settlement conference, or the weekly review panel may provide approval for the supervisor of the respondent. It is further

ORDERED, that pursuant to the March 4, 1991 consent order, the respondent is obliged to complete his normal continuing medical education requirements plus twenty-five hours of board approved class I continuing medical education credit by March 4, 1992. The respondent shall, based upon this consent order, attend the Harvard Medical School Update on Obstetrics and Gynecology scheduled to be given in March 1992 in Boston, Massachusetts. The respondent is only required to attend the portion of the Harvard course that deals with obstetrics and obstetric management. The respondent

shall receive continuing medical education credits for this course in the amount authorized by the Harvard Medical School. Credits earned by the respondent for attending the Harvard Review Course may be utilized toward the continuing education requirement of the consent order for the year beginning March 4, 1992, or to meet the normal CME requirements for a practicing physician; and be it further

ORDERED, that should the respondent fail to abide by the conditions set forth in this supplemental consent order, the board may act upon that failure as a violation of probation pursuant to the March 4, 1991 consent order.

It is further ORDERED, that the provisions regarding reinstatement and retirement of the March 4, 1991 consent order shall remain in effect. This supplemental consent order shall not extend the time period of the March 4, 1991 consent order; and be it further

ORDERED, that the respondent will be responsible for all costs incurred under this consent order; and be it further

ORDERED, that this consent order is considered a public document pursuant to *Md. State Gov't Code Ann. §10-611 et seq.*

ISRAEL H. WEINER, M.D., Chairperson
Maryland Board of Physician Quality Assurance

Consent

By signing this consent, I hereby accept and agree to be bound by the foregoing consent order and its conditions and restrictions consisting of eight pages.

1. By signing this consent, I hereby do not admit the truth of the findings of fact or agree with the charges or the conclusions of law. Indeed, I dispute and deny any liability or wrongdoing. However, I submit to the foregoing order and a desire to settle and resolve this litigation.
2. I hereby acknowledge the validity of this order as if made after a hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by law.
3. I also recognize that I am waiving my right to appeal any adverse ruling of the board that might have followed any such hearing. By this consent I waive all such rights.
4. I sign this order after having an opportunity to consult with an attorney, without reservation, and I fully understand its meaning and affect.

SARKIS SARKISSIAN, M.D. ■

A Clinical Moment with...Diabetes

The importance of measuring microalbumin

Doctor, I have had diabetes for ten years, since age 13. I have been followed by a pediatrician and have just recently begun to see a diabetes specialist. After my first visit, he asked me to collect an overnight urine specimen to check on my kidneys. What was my doctor looking for, and is this something that I should have been doing before? If my doctor finds something wrong, is there anything that can be done?

Your doctor was asking you to collect a urine specimen to measure microalbumin or very small amounts of albumin and other proteins in the urine. When a urinalysis is done, a semiquantitative test for protein is included by using a dipstick and measuring a color change. This test is only positive when fairly large amounts of protein are present. The microalbumin test is much more sensitive and will be able to measure amounts of albumin the dipstick cannot see.

The importance of measuring microalbumin is that its presence suggests the existence of early diabetic nephropathy (kidney disease). Elevated levels of microalbumin have been shown to be predictive of the later development of clinically significant kidney disease. Annual assessment of microalbumin will allow your doctor to follow your kidney function and detect early kidney involvement. As many as 50 percent of patients with type I diabetes will eventually develop renal disease, usually between fifteen and twenty-five years after the onset of diabetes.

If there were no therapy or way to alter the course of diabetic renal disease, than this knowledge could be con-

sidered to be unnecessary or even counterproductive—just giving the patient something else to worry about. Although research on the prevention of nephropathy is in its early stages, there are some good studies that suggest that the course of nephropathy can be changed.

Blood glucose control may have a positive effect on early diabetic renal disease. For example, if a kidney from a diabetic donor who has early nephropathy is transplanted to a non-diabetic recipient, the early changes of kidney disease may disappear. Results for tight control of diabetes are not as clear-cut, but some studies have shown a benefit in preventing progression.

Restriction of dietary protein in animals and man has also been shown to be of benefit in retarding the deterioration of kidney function in diabetes.

Finally, several good studies using antihypertensive medications that block the production of angiotensin II (angiotensin-converting inhibitors) have shown that patients treated with the ACE inhibitors have had less or no progression of proteinuria when compared with patients who have been given a placebo.

In summary, it is important for your doctor to measure microalbumin in the urine annually, so that the presence of an early warning of diabetic kidney disease can be detected. It is hoped that this will allow early treatment and prevention of the development of severe renal disease.

JAMES H. MERSEY, M.D.

Editor



As of this issue, I have assumed responsibility for the content and direction of this column. Dr. Dewitt DeLawter has voluntarily passed this torch on to me. Dr. DeLawter wrote this column nearly singlehandedly over many years, providing much useful information and a continually current perspective on the modern management of diabetes.

It would be difficult, if not impossible, to duplicate his effort. Rather than try to write this column alone, I intend to have this column make use of the many local experts in diabetes and its related conditions. As editor, I will attempt to keep the reader current on new developments, management strategies, and social issues related to diabetes. These will not be review articles, but will continue to be written by myself or other contributors as replies to questions, in language that can be easily understood and used to communicate with patients.

I welcome suggestions for topics or other ways to improve this column as I accept the stewardship of A Clinical Moment with ... Diabetes.

JAMES H. MERSEY, M.D.



The Maryland Medical Journal (MMJ) is a monthly publication of the Medical and Chirurgical Faculty of Maryland. The journal's goals are educational and informative: the publishing of scientific articles (original research, case studies, and review articles) and other technical information, as well as editorials, letters, special articles (evaluations, position papers, reviews of nonscientific subjects),

Information for AUTHORS

membership and legislative news, continuing medical education notices, and programs and policies of the faculty.

- **Letter of transmittal**—The letter of transmittal, which all authors must sign, should include the full names, degrees, titles, and affiliations of all authors, and the name, address, and phone number of the author to whom reprint requests and correspondence should be sent.

The letter should include a statement to the effect that all authors have participated in the conception and design of the work and in the writing of the manuscript, and that they take public responsibility for it. The authors should attest to the validity and legitimacy of the data, and acknowledge that they have reviewed the final version of the manuscript and approve it for publication.

In addition, the letter must include a paragraph that transfers copyright ownership to the *MMJ* in the event that the work is published.

- **Manuscript preparation**—Manuscripts should be submitted to Editor, *MMJ*, 1211 Cathedral Street, Baltimore, MD 21201-5585. Manuscripts must be original material not previously published and not under consideration by another publication. A synopsis/abstract of 30 to 50 words (maximum) is required.

All material, including references, tables, and legends, must be double-spaced. Pages should be numbered. (All abbreviations should be spelled out on first use.) The original manuscript plus one copy should be submitted on standard (8.5" x 11") bond paper. If at all possible, an IBM-compatible disk should be included, with the manuscript entered in a WordPerfect, Multimate, Wordstar, or ASCII format; the transmittal letter should identify the format used.

- **References**—References are limited to those citations noted in the text. References should be numbered consecutively as they appear in the text and should be kept to a minimum (fewer than thirty-five). Personal communications and unpublished data are not acceptable. At a minimum, references should include names of all authors, complete title of the article cited, name of journal abbreviated according to *Index Medicus* (if abbreviation is not known, journal name should be spelled out fully), year of publication, volume number, and first and last page numbers. Sample references are as follows:

1. Stevens MB. The clinical spectrum of SLE. *Md Med J* 1991; 10:875-85.

2. Ropes MW. Characteristics, manifestations, and pathologic findings. In: Ropes MD, ed. *Systemic Lupus Erythematosus*. Cambridge, MA: Harvard University Press. 1976; 50-4.

- **Tables**—Tables should be typed on separate sheets of paper, be numbered, and have a brief descriptive title. Data presented in tables should be self-explanatory and should supplement, not duplicate, the text; the Editor reserves the right to edit tables. Authors should be sure that statistics are consistent in both tables and text.

- **Illustrations**—Illustrations include material that cannot be set in type. Photographic material must be submitted as high-contrast, glossy prints. Drawings and graphs must be done professionally in india ink on high-grade white drawing paper or be computer generated. Identification—including figure number, the title of manuscript, the name of corresponding author, and arrow indicating top—should be typed on a gummed label and affixed to the back

Checklist

- ☐ Original manuscript and one copy.
- ☐ IBM-compatible disk in WordPerfect, Multimate, Wordstar, or ASCII.
- ☐ Everything double-spaced.
- ☐ Letter of transmittal, signed by all authors, that includes release of copyright, statement of authorship responsibility, title and affiliation of all authors, and identification and phone number of corresponding author.
- ☐ Thirty to fifty word synopsis.
- ☐ Permission-to-borrow letters for any previously published illustrations or tables.

of each illustration. Legends for illustrations should be typed on a separate page with numbers corresponding to those on the photographs or drawings. Recognizable photographs of patients are to be masked and should carry with them written permission for publication. Cost of printing color photographs must be borne by the author.

- **Permissions**—Material taken from other sources must be accompanied by written permission from both author(s) and publisher allowing the *MMJ* to reproduce the information/figure.

- **Editorial responsibility**—All manuscripts are acknowledged upon receipt. They are subject to peer review by an editorial board and, at times, by guest reviewers in appropriate fields of medicine, to determine the originality, validity, and importance of the content and conclusions. Authors are usually notified of the status of their papers (acceptance, revision, or rejection) within 4 to 8 weeks of receipt; however, longer delays are sometimes unavoidable. Reviewers' comments will be returned with rejected manuscripts at the discretion of the Editor. All guest reviewers will remain anonymous.

Accepted manuscripts become the permanent property of the *MMJ* and are subject to copy editing. (The *Chicago Manual of Style* and the unabridged *Random House Dictionary of the English Language* are used as style guides.) The corresponding author is sent a reprint order form and galley proofs. S(he) then has 48 hours in which to make minor changes and clear all corrections and changes with co-authors; if proofs are not returned by the specified date, they will be considered approved as typeset. ■

William Donald Schaefer - Governor of Maryland



EPIDEMIOLOGY & DISEASE CONTROL PROGRAM

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Department of Health & Mental Hygiene

J. Mehseu Joseph, PhD - Director
Community Health Surveillance & Laboratories Admin.

Ebenezer Israel, MD, MPH - Director
Epidemiology & Disease Control Program

Inquiries and Responses Concerning Infectious Disease Issues

June, 1992

The Epidemiology and Disease Control Program regularly receives inquiries regarding a myriad of infectious disease issues. As the questions encountered by our staff may be ones similarly faced by many health professionals, selected questions are noted below.

Tetanus Vaccine and Pregnancy

Inquiry: A 5-week pregnant woman incurred cuts on her finger with a tin can. The 35-year-old woman is unsure of her tetanus vaccination status; her gynecologist recommends a tetanus shot. The woman is concerned about pregnancy as a contraindication of receiving tetanus or tetanus-diphtheria (Td) vaccine.

Response: The tetanus or Td vaccine is not known to cause special problems for pregnant women or their unborn babies. Pregnant women who need Td vaccine should receive it.

Control Measures for Lice in a Nursing Home

Inquiry: What control measures should be instituted when head lice is documented in one nursing home resident?

Response: Treat the infested person with a permethrin-based product (such as Nix). Check contacts (both employees and other residents) for evidence of lice; treat if infested.

Scarlet Fever and Quarantine

Inquiry: Does a six-year-old diagnosed with scarlet fever by a physician require quarantine? Can the child play with neighbors? The child has been on penicillin for one day.

Response: With adequate penicillin therapy, transmissibility is generally terminated within 24-48 hours. While strict quarantine is not indicated for scarlet fever, DHMH guidelines recommend that children with scarlet fever should be excluded from child care and/or school until 24 hours after treatment. Regarding neighborhood playmates, the caller may wish to keep the case away from direct/intimate contact with others for an additional day.

Management of a Foodhandler with Salmonellosis

Inquiry: What is the appropriate management for a foodhandler who is currently symptomatic and culture positive for *Salmonella*? No additional cases of gastroenteritis have been reported by the physician.

Response: Emphasize handwashing and exclude the case from foodhandling until stool cultures are negative for *Salmonella* on three consecutive samples collected at least 24 hours apart (and 48 hours after antibiotic use). There is no need for an expanded investigation since no other cases have been reported.

Bar Soap as a Vehicle for Disease Transmission

Inquiry: Can viral gastroenteritis be transmitted via bar soap?

Response: While the Centers for Disease Control have recovered bacteria from hand (bar) soap, no transmission via hand soap has been documented. Outbreaks

have been traced to antiseptic liquid soap but not to bar soap. Ordinary hand soap is recommended for routine non-invasive procedures.

Management of a Tick Bite

Inquiry: What measures should be taken after a tick bite that has not resulted in rash or other symptoms?

Response: Seek medical attention if a rash or skin lesion develops. Prophylaxis with antibiotics for tick bites that do not result in symptoms is *not* recommended.

Removal of Ticks

Inquiry: What should be placed on a deer tick to retrieve it from the skin?

Response: Do not place anything on the tick. Remove tick with tweezers, grasping the insect as close to its mouth parts as possible and pulling straight out. Wash the affected skin area and apply a mild disinfectant such as alcohol or hydrogen peroxide.

Testing of Ticks

Inquiry: Can ticks be tested for spirochete infection?

Response: Ticks can be tested for spirochetes, however, the State Health Department Laboratory does not provide this service since infected tick bites do not always lead to Lyme disease. Also, ticks need to be attached to the body over 24 hours to be able to transmit the disease.

Number of DTP Doses

Inquiry: Both the Immunization Practices Advisory Committee (ACIP) and the American Academy of Pediatrics (AAP) recommend 5 doses of DTP (diphtheria, tetanus, and pertussis) vaccine at or before the time of school entry. In contrast, Code of Maryland Regulation (COMAR) 10.06.04 requires only 4 doses for entry into Maryland schools. Which recommendation should a private physician follow?

Response: The ACIP and AAP recommendation of 5 doses should be followed.

COMAR specifies the *minimum* number of DTP doses required for school entry.

Indication for Use of Meningococcal Vaccine

Inquiry: Is meningococcal vaccine indicated for an asplenic person?

Response: Yes, meningococcal polysaccharide vaccine is recommended for particular high-risk groups, including those with anatomic or functional asplenia. However, routine vaccination of civilians with meningococcal polysaccharide vaccine is not recommended.

Revaccination with Pneumococcal Vaccine

Inquiry: A Patient who had received pneumococcal polysaccharide vaccine was inadvertently given a second dose of the vaccine 30 days later. The patient was being kept under surveillance at a physician's office due to concern over the possibility of an anaphylactic reaction. How should this patient be managed?

Response: Except for certain high risk groups, pneumococcal vaccine should be given only once since Arthus reactions and systemic reactions have been noted among adults given additional doses. While reactions may occur following a repeat dose, anaphylaxis is rare. The physician was advised to send the patient home and to instruct him/her to seek medical attention should a serious local reaction occur.

Hepatitis B Postexposure Prophylaxis

Inquiry: A previously unvaccinated nurse received an accidental needle stick from a patient with unknown hepatitis B status. The needle stick occurred six days ago. Should the nurse receive HBIG (hepatitis B immune globulin) in conjunction with the vaccine?

Response: For accidental percutaneous exposure to blood, the decision to provide prophylaxis must include consideration of several factors: 1) whether the source of the blood is available, 2) the HBsAg status of the source, and 3) the hepatitis B vaccination status of the exposed person. If the source of exposure is HBsAg-positive, HBIG should be given along with

hepatitis B vaccine. Otherwise (when source is HBsAg-negative or not tested or unknown) only the vaccine is recommended. When indicated, HBIG should be given as soon as possible (its value beyond 7 days after exposure is unclear). In this particular instance, since the nurse was not previously vaccinated, hepatitis B vaccination should be given within 7 days of exposure.

Timing of DTP Vaccination

Inquiry: A patient received the fourth dose of DTP 5 1/2 months after the third dose. Since the minimum interval between the third and fourth dose of DTP is 6 months, should the child get another DTP shot in 2 months to "replace" the fourth dose?

Response: Doses of DTP given at less than recommended intervals may lessen antibody response. However, due to this child's age, previous history of 3 DTP shots, expectation of a fifth dose after age 4, and lack of pertussis activity in the area, revaccination was *not* recommended.

Treatment of Pregnant Woman with Syphilis Titer 1:4

Inquiry: Two years before becoming pregnant, a woman was diagnosed with primary syphilis (1:256) and treated with benzathine penicillin. No follow-up serologies were done. In the last 2 years the woman claims having had only one sexual partner who was tested three months ago and found negative. The woman now has a titer of 1:4. Should this patient be treated?

Response: In this particular instance, treatment is indicated. While the woman is probably serofast, in the unlikely event that she is not, treatment will protect the baby.

Occupational Exposure Incidents to Syphilis

Inquiry: What is the recommendation of the U.S. Public Health Service for blood/body fluid exposure to *Treponema pallidum* (the causative agent of syphilis).

Response: Formal studies have not been carried out defining the risk associated

with such exposures or comparing the efficacy of differing methods of managing exposed individuals. The lack of well-documented reports of syphilis infection following exposure to patient material other than overt syphilitic lesions suggests that the risk of transmission is low, probably because of the low concentration of spirochetes outside of syphilitic lesions. Theoretically, the risk of transmission would be greatest during the early stages of syphilis when the concentration of spirochetes in blood and body fluids is generally highest.

At a minimum, health care workers exposed to blood/body fluid possibly contaminated with *Treponema pallidum* should be followed for three months following the exposure. There is lack of information on comparing the risks of (1) immediate treatment for early syphilis infection prior to documentation of transmission with (2) the risks of withholding treatment until transmission is established. In the absence of evaluation studies, the choice between these two approaches is necessarily a matter of judgement.

If treatment is withheld, follow-up should probably occur at least weekly during the first month and at least biweekly during the second and third months. Follow-up should include: (1) history for the development of lesions at the site of exposure and for nonspecific symptoms of systemic infection; (b) examination of the site of exposure for signs of infection; and (c) serologic tests for syphilis. Standard therapy for early syphilis should be administered if physical examination or laboratory signs of syphilis develop (benzathine penicillin, 2.4 million units, intramuscularly). The risks of any adverse consequences of syphilis infection given such follow-up should be quite low.

Alternatively, recommended treatment for early syphilis could be administered immediately upon the individual's presentation following exposure. Treatment is highly effective. Allergic reactions to penicillin are a concern, but serious reactions are uncommon. The stage of syphilis of the source individual, quantity

of blood/body fluid involved in the exposure, cost of followup, likelihood that the exposed individual will comply with follow-up, time required to obtain results of serologic tests for syphilis, and level of anxiety of the exposed individual should be considered. Immediate treatment is probably indicated for pregnant women, due to the additional risks of adverse consequences for the fetus.

Contacts of Patients with Sexually Transmitted Diseases (STD)

Inquiry: Why do you need to prophylactically treat the sexual contacts of STD patients?

Response: You treat in order to stop the spread of infection. Many times contacts can be treated while still in the incubation phase of an STD (e.g., syphilis) and they, therefore, avoid developing the disease.

Treating partners also minimizes the chance of reinfection to the original patient.

Cooperation of the private physician in treating sexual partners is crucial in reducing the prevalence of STD's in the community.

Maryland regulations require physicians to notify the local health departments if the partners of the STD cases need treatment and follow-up.

International Travel

Inquiry: How do I get information on international travel?

Response: The Centers for Disease Control in Atlanta operates on a 24 hour international travel hotline (Telephone: 404-332-4555).

Recommendations for Visiting Malaria Endemic Areas

Inquiry: What do you recommend to a traveller who is visiting a malaria endemic area?

Response: Assess the risk of chloroquine-resistant malaria in the areas visited.

Avoid contact with malaria-transmitting mosquitoes which feed primarily between

dusk and dawn. Take preventive measures such as remaining in well-screened areas, using mosquito nets when sleeping and covering most of the body. Additionally, use of mosquito repellent is recommended.

Malaria chemoprophylaxis should preferably begin 1-2 weeks before travel and continue during travel and for 4 weeks after the person leaves the malarious area.

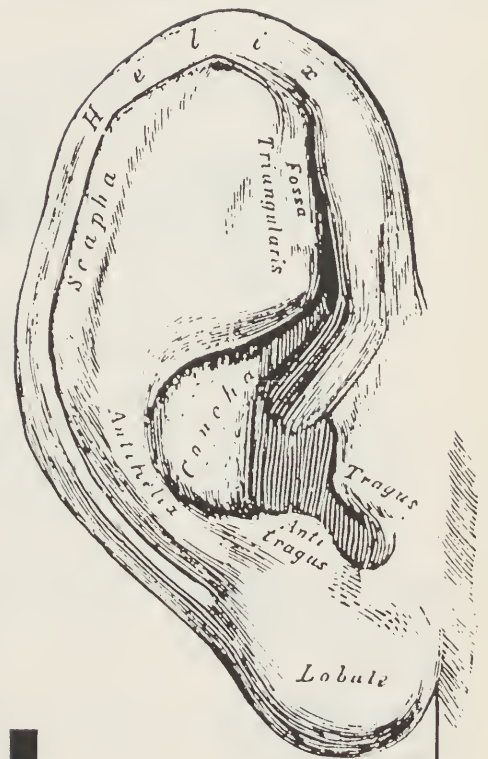
Mefloquine 250 mg in a week is recommended. Mefloquine should not be used for children weighing less than 30 pounds. Also, it is contraindicated for use during pregnancy which makes it inadvisable for pregnant women and very small children to travel to areas with chloroquine-resistant malaria.

Management of a Pregnant Teacher Exposed to Chickenpox

Inquiry: A pregnant school teacher is exposed to a student with chickenpox. The school teacher is unsure whether she had had chickenpox before. How should she be managed?

Response: The pregnant teacher should check with her doctor since each person exposed to chickenpox needs to be individually evaluated. The risk to the pregnant woman or to her fetus will depend on whether the woman is already immune to chickenpox. The woman can be tested if results can be obtained within four days after exposure. If VZV (varicella zoster virus) antibody is not detected or if results cannot be obtained within four days after exposure, VZIG (varicella zoster immune globulin) may be recommended. The primary indication for VZIG in a pregnant woman is to prevent complications of varicella in her rather than to prevent intrauterine infection.

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PHYSICIAN'S RECOGNITION AWARD

During March 1992, the physicians listed below received the American Medical Association's (AMA's) Physician's Recognition Award. Established in 1968, the Award's purpose is to encourage physician participation in continuing medical education and to recognize those physicians who have voluntarily completed programs of continuing medical education.

Selwa A.F. Al-Hazzaa
Arthur Saxton Blank
Boland, James Edward
Wisit Boonn
Jaime F. Botello
Lorin Fred Busselberg
Frantz Xavier Celestin
Arnold Lee Dellon
Maria Del Carmen Diaz
Michael Samuel Epstein

Robert Bruce Helmly
George Richard Hilty
Perry Hookman
Niklaus J.A. Keller
Robert Y. Kim
Stephen Hall King
Harvey Anthony Lewis
Allen E. Marans
David Painter Mohr
John Francis O'Neill

Irvin Paul Pollack
Bonnie B. Potter
Shira Hope Rubinstein
Maxine A. Schurter
Bernard Richard Shochet
Donald Scott Stepita
Harold Stevens
B Bernard Stopak
Raymond Kief Thompson
Alan R. Weinstock

During April 1992, the physicians listed below received the American Medical Association's (AMA's) Physician's Recognition Award. Established in 1968, the Award's purpose is to encourage physician participation in continuing medical education and to recognize those physicians who have voluntarily completed programs of continuing medical education.

Leslie Abramowitz
Robert Thomas Adkins
Selwa A.F. Al-Hazzaa
David Alyono
Roger Wilbert Anderson
H. Jack Baghdassarian
Robert Joseph Bauer
Lillian B. McLean Beard
Larry Becker
Georges Curtis Benjamin
Gershon Henoch Bergeisen
Michael A. Bolognese
Robert Leonard Brenner
David Earl Bush
Benjamin H. Caballero
Marcia D. Coe
Robert Nelson Conrad
Gordon B. Cutler
Josphe John Drabick
Michael Lewis Dvorkin
Mehdi Pour Farzin
Michael A. Franchetti
Paul Frank Giannandrea
George Travers Gilmore

David Brian Glasser
Michael Cary Goodman
Ching-Jou Gou
Richard Lee Gross
Gregory Gurfinkel
Martin Helrich
Joseph James Higgins
Jeffrey Peter Indrisano
Darrell Arthur Jaques
Harry Robert Katz
Antoine Elias Kfuri
Shin Eung Kim
Arnold A. Lear
Albert K. Lee
Yu-Jin Lee
Peter Erwin Linz
Philip London
William Paul Magdycz
Richard Anthony Marasa
Wayne Alan McWilliams
Donald Chamberlin Meek
Eltag Siddig Mirghani
Russell Wyman Moy
Jowheri J. Mullick

David Augustus Nagey
David Michael O'Neil
Carl Arthur Patow
Lawrence David Pinkner
Glen Irving Reeves
Jack Jacob Rheingold
William James Richtsmeier
Hugo V. Rizzoli
Jose Tadeo P. Ruiz
Marcel Edward Salive
Russell Owen Schub
Ajaib Singh Sidhu
Henry A. Spindler
Farouk Ahmed Sultani
Victoria L. Thornton
Kenneth G. Torrington
Phuong Duc Trinh
David Schick Trump
Arturo C. Uy
Herbert Winston
Raymond Arthur Yerg
Ruthann Teresa Zern

Miscellaneous meetings

- | | |
|--|-------------------|
| Evolution of critical care to the year 2000 , sponsored by the Baltimore City Medical Society, at Church Hospital, Baltimore, MD. 1 Cat 1 AMA/PRA credit; 1 AAFP prescribed hour. Fee: none. Info: Lorraine Wallace, 410-625-0022. | June 4 |
| Third millennium conference involving children in community partnerships to control parasitic disease and end hidden hunger , sponsored by the International Medical Services for Health (INMED), at the Omni Shoreham Hotel, Washington, DC. 15 Cat 1 AMA/PRA credits. Fee: \$415. Info: 703-444-4477 or 800-521-1175. | June 9-12 |
| A focused seminar on peripheral pain , sponsored by the Washington Adventist Hospital, at the Hyatt Regency Bethesda, Bethesda, MD. Info: Robert Gerwin, M.D., 301-982-7944. | July 17-19 |
| Initial thoughts on the city and state: Dean Donald Wilson, M.D. , sponsored by the Baltimore City Medical Society, at St. Agnes Hospital. 1 Cat 1 AMA/PRA credit; 1 AAFP prescribed hour. Fee: none. Info: Lorraine Wallace, 410-625-0022. | Sept. 3 |

Continuously throughout the year

Fluorescein angiography conference, sponsored by the Retina Center at St. Joseph Hospital, first and third Mondays of each month; 8:00-9:00 a.m. Fee: none. Info: R. Classon, 410-337-4500.

Shady Grove Adventist Hospital,

9901 Medical Center Drive, Rockville, MD. Info: 301-279-6115.

- | | |
|---|-----------------|
| Performing arts medicine. | June 4 |
| Smoking cessation. | June 11 |
| Noninvasive assessment of coronary artery disease. | June 18 |
| Dangerous marine organisms. | June 25 |
| Pain control in the cancer patient. | July 2 |
| Pediatric cancer. | July 9 |
| Rheumatology. | July 16 |
| Depression: Treatment in the office setting and comparison of newer and older agents. | July 23 |
| Current concepts in plastic surgery. | July 30 |
| Risk management. | Aug. 13 |
| New developments in the treatment of asthma. | Aug. 20 |
| The noninvasive peripheral vascular lab. | Sept. 10 |

Physician Placement Services

The Medical and Chirurgical Faculty of Maryland maintains a Placement Service for the convenience of Maryland physicians, hospitals, and communities in search of candidates for positions available in our state. A detailed description of such opportunities should be forwarded to:

Physician Placement Service
1211 Cathedral St., Baltimore, MD 21201-5585
(301-539-0872)

Physicians wishing to locate in Maryland are invited to submit a resume to be kept on file with the *Physician Placement Service*. Candidates are requested to inform the Faculty when they are no longer available for consideration for opportunities in Maryland.

MMJ announcements on the Classified Advertising page for Physician Placement Service are charged at the regular Classified Advertising rate.

The Johns Hopkins Medical Institutions

All courses at the Turner Auditorium unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Education, 720 Rutland Ave., Baltimore, MD 21205 (410-955-2959).

- Symposium on the prevention of developmental disabilities in infants and toddlers.** 14 Cat 1 AMA/PRA credits. Fee: \$200 physicians; \$100 residents, fellows, and allied health professionals. **June 4-5**
- Control of biohazards in the research laboratory.** Info: Dr. Jacqueline Corn, 410-955-2609. **July 13-17**
- Endoscopic sinus surgery: Hands-on laboratory and lecture.** 19 Cat 1 AMA/PRA credits for lab and lectures. 14.5 Cat 1 AMA/PRA credits for lectures only. Fee: \$1,250 lab and lecture; \$295 lectures only. **Aug. 13-15**
- Laryngeal disorders: Hands-on colloquium, laboratory and workshops.** Cat 1 AMA/PRA credits pending. Fee: \$1,000 colloquium and lab; \$400 colloquium for physicians; \$225 colloquium for residents and allied health professionals. **Sept. 10-12**
- 34th annual Emil Novak Memorial Course: Gynecology, gynecological pathology, endocrinology, and high risk obstetrics.** 53 Cat 1 AMA/PRA credits; 51 ACOG cognates. Fee: \$675 physicians; \$475 residents, fellows, and allied health professionals. **Oct. 12-17**
- Update on sinusitis for the practitioner.** 9 Cat 1 AMA/PRA credits. Fee: \$175 physicians; \$95 residents, fellows, and allied health professionals. **October 30**

Continuously throughout the year

- Visiting preceptorship in pediatric critical care medicine.** Ongoing five-day preceptorship by appointment. 40 Cat 1 AMA/PRA credits. Fee: \$600.
- Ophthalmic electrophysiology technician training course.** Ongoing one-week course by appointment. The Wilmer Eye Institute, Baltimore, MD.
- Ophthalmology grand rounds.** Audiovisual continuing education series of case discussions for clinicians; 3-8 topics per conference. Thursdays, 7:30-9:00 a.m. 2 Cat 1 AMA/PRA credits per session. Info: 410-955-5700.
- Neuro-ophthalmology conference.** Held twice per month. Info: 410-955-5700.
- Cornea conference.** Held monthly. Info: 410-955-5700.
- The department of radiology and radiological sciences** offers several courses in abdominal and obstetrical ultrasound. Info: P. Williams, 410-955-3169.
- Visiting physicians.** Offered throughout the year for experience in the lab and participation in read-in sessions; by appointment only. 40 Cat 1 AMA/PRA credits. Fee: \$500.
- Johns Hopkins medical grand rounds.** Accredited audiovisual continuing education series of case discussions for clinicians; thirty topics per year in five bimonthly programs. Individual and group subscriptions. 40 Cat 1 AMA/PRA credits. Info: 410-955-3988.
- Microsurgery training at the Johns Hopkins Hospital.** One-week program offered continuously throughout the year. 40 Cat 1 AMA/PRA credits. Info: P. Williams, 410-955-3169.

University of Maryland

For each course, additional information may be obtained by contacting the Program of Continuing Education, University of Maryland School of Medicine, Room 14-011, BRB, 655 W. Baltimore St., Baltimore, MD 21201 (410-328-3956) or by calling the phone number listed after a specific program. FAX 410-328-3103.

- AIDS, women and reproduction: Medical, legal and ethical challenges**, sponsored by the Maryland AIDS Professional Education Center, in Baltimore, MD. Info: Sylvia Scherr, 410-328-8639. **June 11**
- 18th annual family medicine review course**, in Ocean City, MD. 26.5 Cat 1 AMA/PRA credits. Fee: \$395. Info: Sharon Stenhouse, 410-328-3956. **June 21-26**
- 11th annual update in obstetrics and gynecology**, in Annapolis, MD. Info: Sharon Stenhouse, 410-328-3956. **June 25-26**
- HIV Coordinator Skills Course**, sponsored by the Maryland AIDS Professional Education Center, in Salisbury, MD. Info: Gwen Kergides, 410-328-8639. **Sept. 24-25**

Continuously throughout the year

- Visiting professor program.** A 1992 directory of speakers and their topics is available to area hospitals and other health care organizations. NO administrative fees are charged for this service. Info: 410-328-3956.
- Departmental rounds and conferences.** Weekly, hands-on, and lecture presentations hosted by the University's clinical departments. Hour-for-hour Cat 1 AMA/PRA credits available. Brochure available.
- Pediatric grand rounds.** Every Thursday from September to June, except third Thursday, in the R. Adams Cowley Shock Trauma Auditorium. Info: Bonnie Winters, 410-328-6777.

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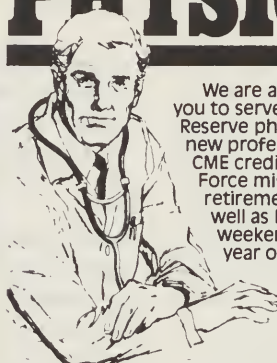
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- Helped establish the smoking ban on domestic commercial airline flights of two hours or less;
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Growing group practice affiliated with the largest HMO in Maryland seeks additional BC/BE physicians in Internal Medicine, Family Practice and Pediatrics. Positions available in Baltimore and surrounding metropolitan areas. Reply with C.V. to Daniel J. Winn, M.D., P.O. Box 13126, Baltimore, MD 21203-3126.

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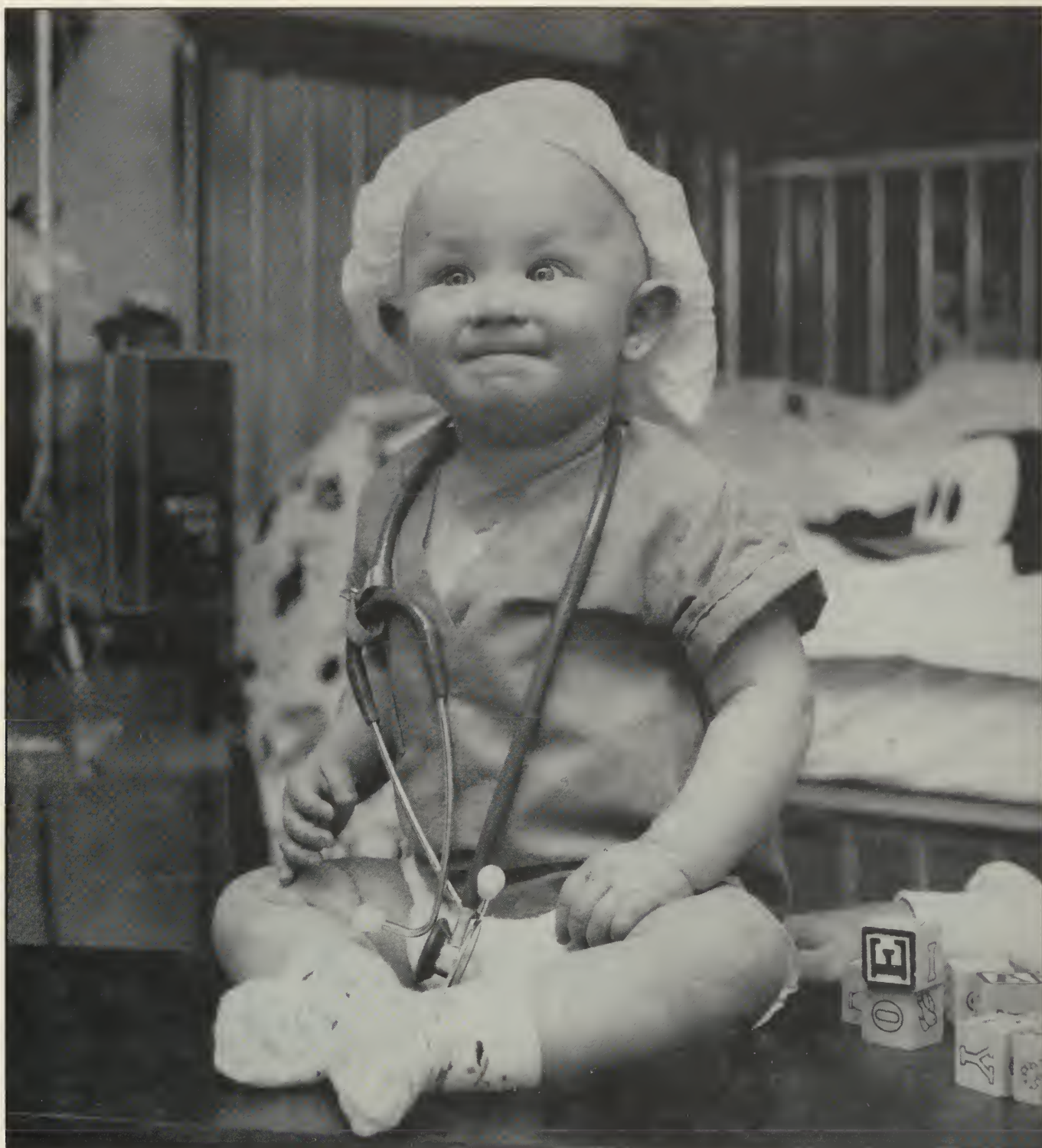
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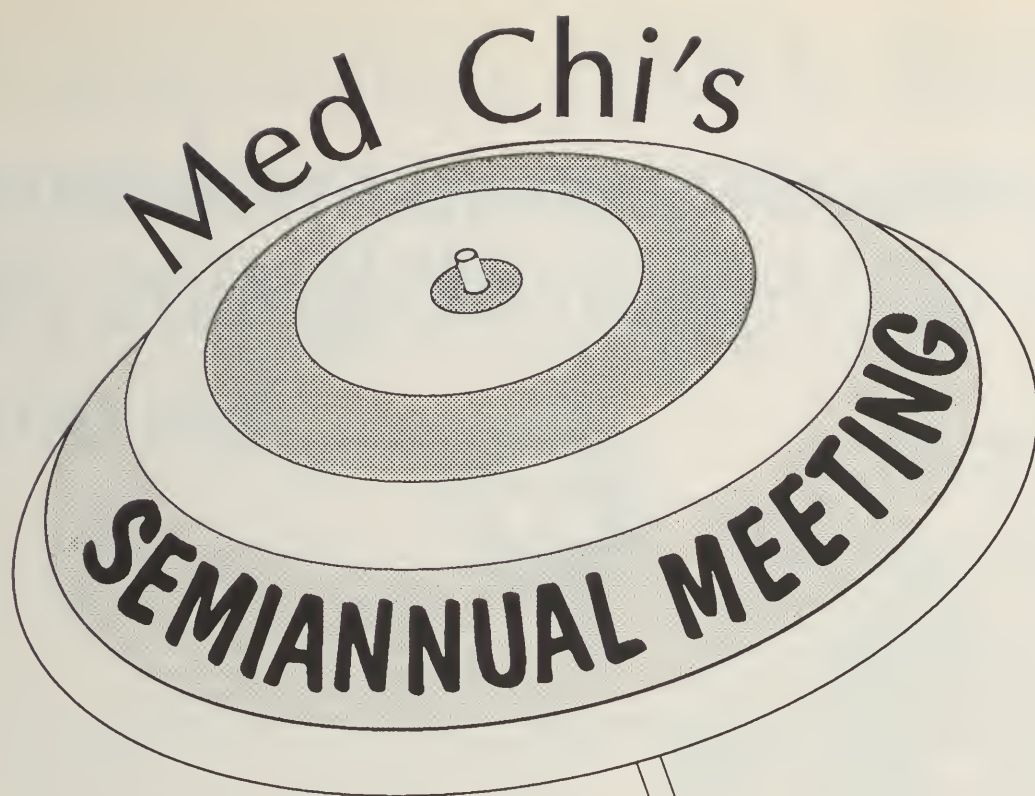
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Watch the July Issue of the *MMJ* and the *Executive Director's Newsletter* for more information on business meetings and scientific programs at the 1992 Med Chi Semiannual Meeting.

WHY SHOULD YOU REFER CHILDREN AND ADOLESCENTS WITH SPINA BIFIDA TO CUMBERLAND HOSPITAL?

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Each year, some 200 pediatric patients ages 2-22 needing rehabilitation and behavior management are admitted to Cumberland Hospital for Children and Adolescents. While many hospitals provide excellent medical treatment, Cumberland adapts its programs to meet the social and psychological needs of young people.

Treatment is often incorporated into traditional adolescent activities. For example, treatment may include a basketball or volleyball game played in the gymnasium or the swimming pool. Individual mobility goals may be tested and explored during an outing to one of the local parks such as Busch Gardens (amusement park), Jamestown, Yorktown or Williamsburg.

For the young person with spina bifida, there is always a new challenge and a new opportunity to stretch his or her abilities and confidence.

Functional Mobility and Independence

The most visible and often most emotionally charged issue for the young person with spina bifida is mobility. Almost all children with spina bifida wear orthoses, and many use wheelchairs. Ambulatory skills are often achieved late and tend to reach a maximum in the 5- to 8-year-old age group.

With the approach of adolescence, there are increases in weight and height that make ambulation more difficult and less cosmetic.



Difficult decisions must be made regarding the young person's future. Cumberland assists patients and their parents in determining the form of mobility that is most acceptable to them, and help them structure their lives accordingly.

Adolescence is also a time when all young people begin to become independent, and independence for the young person with spina bifida means they take responsibility for their bowel and bladder program and for donning and doffing their braces.

Cumberland evaluates the gross and fine motor skills of the patients as well as their level of intellectual functioning. This information is needed to assist patients and their parents in setting reasonable expectations. Behavior and therapy programs are structured around these expectations.

Cumberland Is A Hospital

Cumberland is licensed by the Commonwealth of Virginia and accredited by the Joint Commission on Accreditation of Healthcare Organizations. It is one of only a few hospitals in the United States where all the physicians on the admitting staff are Board Certified in their specialty.



Cumberland Doesn't Look Like a Hospital

The hospital looks more like a small college with buildings connected by sidewalks, and picnic tables and recreation facilities are disbursed among the facilities. It is common to see

young people in small groups talking, studying or listening to music. Throughout the day, they go between the dormitory, cafeteria, rehabilitation, school and other buildings.

Depending on their level of physical abilities and behavior program, the young people are given levels of independence on the campus ranging from strict one-on-one staff supervision to free movement within the immediate environment.

Young People At Cumberland Go To School

One of the most important elements in the life of a young person is school, and at Cumberland patients go to school. Integrated into the hospital campus is Cumberland Academy—a licensed private school. The building includes classrooms, a library, prevocational department and gymnasium.

Course work is obtained from each patient's home school and classes are conducted around treatment and rehabilitation programs.

Cumberland Serves Many Different Young People

Cumberland provides treatment for young people with many types of medical and behavioral problems, and this has proved to be very beneficial for the patients with spina bifida. While there are usually a number of young people in the hospital with spina bifida, there are also patients with brain injury, diabetes, seizure disorders, spinal cord injuries, asthma and other conditions.

The young people quickly develop friendships and learn about the "disabilities and abilities" of the other young people. They leave the hospital with their medical needs treated and better able to cope with problems and challenges they encounter.

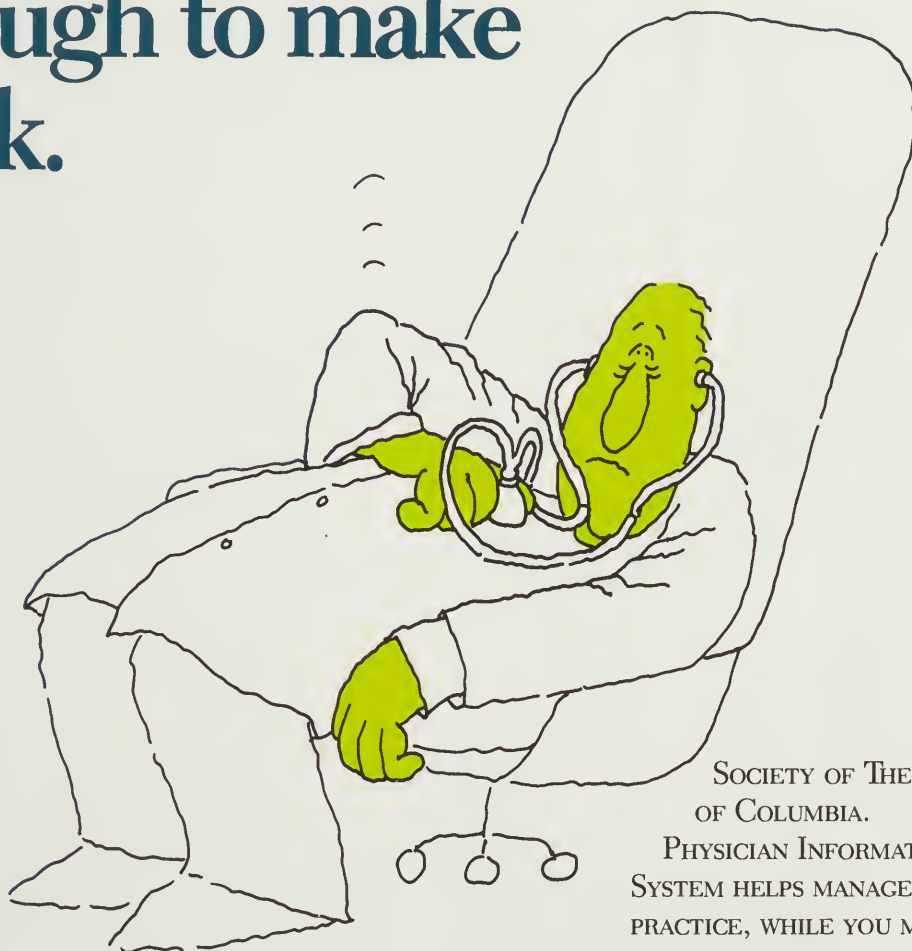
Cumberland's Setting

Cumberland is located on the Pamunkey River and is part of 1,200 acres owned by the hospital. There are three large lakes on the property for fishing and boating, and miles of trails.

For more information on Cumberland Hospital or to refer a patient for treatment, please call the information office at 1-800-368-3472.

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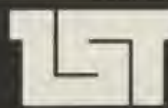


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MMJ

Maryland Medical Journal

JULY 1992

VOLUME 41 NO 7

University of Maryland Medical System:

American medicine's first teaching facility reinvents the academic hospital 595

Stephen C. Schimpff, M.D. and Morton I. Rapoport, M.D.

The University of Maryland Medical School, established in 1807, focused on bedside teaching. This emphasis has continued and expanded through the growth of University Hospital and, ultimately, the University of Maryland Medical System, such that Maryland can now boast of a superb medical care system providing excellent medical education and research opportunities in a patient care setting.

Interferon therapy for multiple sclerosis 601

Kenneth P. Johnson, M.D. and Hillel S. Panitch, M.D.

Laboratory findings that suppressor cell function is improved with beta interferon therapy and that gamma interferon activity is inhibited by beta interferon provide support for the hypothesis that beta interferon will have a significant therapeutic effect on relapse rates in multiple sclerosis.

Laparoscopic general surgery: Current status and future prospects 605

Robert W. Bailey, M.D., Karl A. Zucker, M.D.; John L. Flowers, M.D.; Scott M. Graham, M.D.;

William A. Scovill, M.D.; and Anthony L. Imbembo, M.D.

The capability of performing major abdominal surgery while avoiding a large abdominal incision has clear benefits for patient care. Laparoscopic cholecystectomy can reduce hospital stays and the length of the recovery period, as well as decrease postoperative pain, diminish scarring, and provide significant cost savings.

Aging and humoral immunity 609

Edmond A. Goidl, Ph.D.; Jan Cerny, M.D., Ph.D.; Garnett Kelsoe, D.Sc.; and Dan H. Schulze, Ph.D.

If human antibody responses undergo molecular shifts similar to those identified in mice, the appropriate immunization strategy for the elderly would be a passive administration of the protective antibody from young donors rather than an attempt to boost the individual's own response with a more potent vaccine, because the shifted immune system can no longer make the right kind of antibody.

An overview of follicular development in the ovary:

From embryo to the fertilized ovum *in vitro* 614

Larry D. Anderson, Ph.D. and Anne N. Hirshfield, Ph.D.

We summarize the current knowledge regarding the many events that take place during the transformation of the earliest primordial follicle into a preovulatory follicle, along with brief comments regarding the clinical extension of this elaborate process to the field of assisted reproductive technology.

Progress in understanding the nicotinic acetylcholine receptor through toxin interaction 623

Karen L. Swanson, Ph.D. and Edson X. Albuquerque, M.D., Ph.D.

The need to treat diseases affecting the nicotinic AChR is great, but therapeutic options are few. Through careful correlation of structure-activity relationships of AnTX analogs, we may ultimately be led to the development of diagnostic and therapeutic drugs with specific nicotinic agonist or antagonist activities in the central nervous system that would be of major importance in the treatment of Alzheimer's disease.

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To honor the long and illustrious career of John Dennis, M.D. as dean of the University of Maryland School of Medicine, Benjamin F. Trump, M.D. coordinated the receipt of manuscripts from faculty throughout the medical school. These papers, published in the June and July 1992 issues of the MMJ, reflect the rapid growth and development of research activities that occurred during Dr. Dennis' tenure as dean.

Cover: The University of Maryland at Baltimore logo is superimposed over a photograph of the downtown campus.

Cover design by Susan Ventura.

Photograph courtesy of MIEMSS Media.

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Congressional medical payments: Then and now

Reduction in payment of the fees charged by practitioners for care rendered under Medicare and Medicaid is now a common experience. Over 100 years ago, when President James Abram Garfield was treated for a gunshot wound incurred in Washington, the government also paid only a portion of the fees and expenses billed.

A compromise Republican candidate for the presidency, Garfield was elected over Winfield S. Hancock by only 7,023 votes or 0.08 percent of the total ballots cast for both candidates—although the choice in the electoral college was 214 for the winner and 155 for the loser. After only four months in office, Garfield was assassinated by a disappointed office seeker on July 2, 1881.

As might be expected, the medical response was rapid and the best possible. Four surgeons and two physicians provided care during the period of two-and-a-half months until death occurred.

Garfield was shot in the back twice, but only one bullet entered his body—in the right lower thoracic region about four inches to the right of the vertebral column. Watchful waiting and the care of complications dictated the surgical approach. Curiously, a slight improvement occurred over the first forty-eight hours, but then evidence of a spreading sepsis became apparent. On four separate occasions, drainage of superficial collections of purulent material was either provided or enhanced, but the septic process progressed relentlessly. In the final stages, a right parotitis demanded incision and drainage. Death finally came on September 19. At autopsy, a large hematoma was found in the left upper quadrant of the abdomen. The bullet rested at the lower border of the pancreas after penetrating the body of the first lumbar vertebra. Death was primarily due to a rupture of an aneurysm of the splenic artery. A right subphrenic abscess was a further complication. Curiously, despite the injury to the lumbar vertebra, neurological signs were not present or were not mentioned.

In addition, a large number of other individuals also gave services or furnished supplies. The *Miscellaneous Documents* of the House of Representatives contain a letter from the president of the Board of Audit, sent by the Treasury Department to the Speaker of the House on January 2, 1883.¹ Details of the expenditures and the groups of people applying were identified.

	Asked	Granted
Medical service of six physicians	\$91,000.00	27,500.00
Services and supplies of a miscellaneous nature	17,753.19	6,853.01
Employees of the government for extra work	7,913.99	5,440.00
TOTAL	116,667.18	37,793.01

The doctors received only 30 percent of the sum they requested. They were treated in an equitable fashion, however, as funds for only 34 percent of the entire bill were awarded.

Today, exploration would have been undertaken as soon as the preoperative preparations were at an optimal level. Aseptic surgery, transfusions of blood, the use of antibiotics, splenectomy, and provision for drainage would have given the president an excellent chance for recovery.

Reference

1. Lawrence W. Expenses of President Garfield's illness and death. Miscellaneous Document No. 14, 47th Congress, House of Representatives. January 2, 1883; 1-12.

JOSEPH M. MILLER, M.D.
Timonium

Is there a better way?

Considering the fact that only about 50 percent of the physicians in Maryland are members of the Medical and Chirurgical Faculty and that of the members, only about 10 percent take part in the activities of the organization, there should be a better way to serve the needs of the physicians and to attract greater participation in the organization.

The common complaints of the nonparticipating members are (1) Med Chi is run by a clique and is not democratic, and (2) Med Chi is run by the Baltimore City group.

For the purpose of discussion, we might accept both of these complaints to be valid, but it is only because of membership inertia that it could be true.

Let us dream a little. If 75 percent of the licensed physicians in Maryland were to become Med Chi members and 50 percent of those were to become active participants in the activities of the organization, our legislative clout would be greatly increased, our public relations image would be enhanced, the quality of medical care provided would be improved, and the financial burden per member would be reduced.

How to make Med Chi more beneficial and attractive to members and prospective members? Some suggestions are

1. Revive the long-range planning committee with an open-minded and broad-based membership.
2. Consider discontinuing the semiannual meeting. This would save funds and staff time. Most states have only one meeting per year. The bylaws provide for a special legislative meeting if needed.
3. Overhaul the annual meeting. Some commercial exhibitors

left after the first day this year. It was not worth their time. And it is sad to admit that there were only one or two truly scientific exhibits. For the Maryland physician practicing fifty miles away—and that is most of us—it was not worth the drive and giving up a few days of office or hospital time. Scientific lectures and seminars were the highlight of the meeting. But, were they up to what they could be with three medical schools and the National Institutes of Health within our state borders as source material?

4. Make changes in the meetings of the House of Delegates. The usual distribution of certificates and awards took place at the most recent meeting, as well as recognition of fifty-year members and the reading of the list of this past year's deceased members. The presentation of the Boyer Scientific Lecture by an attorney to an audience of delegates and guests was a surprise and, to some, certainly seemed out of order. The most significant happening was the bitter and

controversial election procedure. This was divisive for the organization and should not have happened.

If the officers and legislators of our state can be elected by popular vote, would it be possible for Med Chi to do the same without going through the intermediary action of the House of Delegates. Such a procedure would go a long way toward overcoming the impression that Med Chi is run by a clique.

It is really time to appoint an active long-range planning committee to develop some new ideas about the annual and semiannual meeting times, locations, and content, as well as a proposed revision of the bylaws to eliminate some archaic methods of doing things. Membership must be increased if we are to survive as a viable force in medicine in Maryland. Let us update our organization to make it more desirable and advantageous to belong to Med Chi.

DEWITT E. DELAWTER, M.D.
Bethesda



Note from the President: The figure of licensed practicing physicians in Maryland who are members of Med Chi has always been reflected to be approximately 80 percent. This is not to say that we should rule out any improvement; in fact, the intent of this letter regarding membership is exactly correct.

Several recommendations mentioned in this letter have already been considered by the Long-Range Planning Committee, especially those suggestions considering the enlargement of the democratic process.

It is always fruitful for members to submit their ideas and we sincerely appreciate this Letter to the Editor.

JOSE M. YOSUICO, M.D.
President

Queen Elizabeth 2



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Executive Director's Newsletter

July 1992

New Room Reservation Number for the Princess Royale Hotel

The Princess Royale Suite Hotel in Ocean City recently changed its room reservation number to: **1-800-4ROYALE** (1-800-476-9253). Plan to attend the 1992 Med Chi Semiannual Meeting on September 18-20, 1992 and call this number to reserve your room at the Princess. The Princess is Ocean City's newest suite hotel that offers your choice of oceanfront or oceanview suites with private balcony and many other amenities (see the ad on page 580 of this *MMJ*). In order to receive the special Med Chi group rate for your suite, you must call the Princess by **August 18, 1992**.

Med Chi Semiannual Meeting

The 1992 Med Chi Semiannual Meeting will be held on Friday, Saturday, and Sunday, September 18, 19, and 20, 1992 at the Princess Royale Suite Hotel in Ocean City, Maryland. A brief outline of the meeting and a registration form are on page 593. A *1992 Semiannual Meeting Preliminary Program* with more detailed information about the meeting will be mailed in August.

1992-1993 Med Chi Directory Coming in August

The 1992-1993 *Med Chi Directory* will be mailed to members in August 1992. All Med Chi members and *MMJ* subscribers will receive a *1992 Semiannual Meeting Preliminary Program* which will be included in the August issue of the *MMJ*. The August issue—a special edition of the *MMJ*—will feature "The Academy Movement: The History of the Origins of the American Academy of Psychoanalysis" by *MMJ* Associate Editor Henry Laughlin, M.D., Sc.D., Sc.S.D.

Special Notice on HCFA 1500 Claim Forms

A. SEMINAR

In order to assist you with the correct processing of the HCFA 1500 claim form, the Medical and Chirurgical Faculty of Maryland will be sponsoring 3 seminars on the claim form. The seminars, conducted by Medicare, will be at our facility: 1211 Cathedral Street, Baltimore, MD 21201

Dates and times:

Wednesday July 8, 1992 9:30 a.m. - 12 noon

Wednesday July 8, 1992 1:00 p.m. - 3:30 p.m.

Tuesday July 14, 1992 9:30 a.m. - 12 noon

Please call your Medicare representative to register for the seminars.

B. HCFA FORMS

On May 1, 1992, Medicare mandated that all claims received on or after 5/1/92 should be on the new 1500 claim form. The new place of service code was also mandatory on the new forms 5/1/92. The majority of providers complied with this request; however, in a one-week period, Medicare of Maryland returned 14,000 new claim forms to providers because the forms came in with the old place of service codes in block 24b and could not be processed. It is imperative that you check the HCFA 1500 claim form booklet (green and white) that Maryland Medicare mailed to you in February 1992 and use the new place of service codes on paper claims.

In brief, the new place of service codes are

11 office	12 home	21 inpatient hospital
22 outpatient hospital	23 emergency room hospital	24 ambulatory surgical center
25 birthing center	26 military treatment facility	31 skilled nursing facility
32 nursing facility	33 custodial care facility	34 hospice
41 ambulance—land	42 ambulance—air or water	51 inpatient psychiatric facility

52 psychiatric facility partial hospitalization	53 community mental health center	54 intermediate care facility/mentally retarded
55 residential substance abuse treatment facility	56 psychiatric residential treatment center	61 comprehensive inpatient rehabilitation facility
62 comprehensive outpatient rehabilitation facility	65 end-stage renal disease treatment facility	71 state or local public health clinic
72 rural health clinic	81 independent laboratory	99 other unlisted facility

A complete description of the places of service are in the booklet.

There has been a misunderstanding with the unassigned numbers. These place of service codes have not been assigned a value yet. Please do not use them on unassigned claims.

Medicare of Maryland's professional relations department has received many questions in connection with the claim form. Listed below are some of the questions and answers that may be helpful to you.

Item 4

Q. Is this the name of the Medicare beneficiary who is the patient or the spouse's name under which there may be other insurance?

A. It is the name of the individual whose other insurance may pay primary to Medicare. If it is the Medicare beneficiary, then the word "same" is to be used to indicate that the other insurance is in the beneficiary's name. If Medicare is the primary payer, and there is no other insurance, then this area of the form is to be left blank.

Item 7

Q. Is this the address of the Medicare beneficiary who is the patient or the address under which the other insurance is listed (e.g., the spouse's address)? Please explain.

A. It is the address of the insured individual named in block number 4. If the address is the same as the patient's, you may use the word "same." This item is only to be completed when block number 4 is completed.

Item 9

Q. What information goes in 9, 9a, 9b, 9c, and 9d?

A. Information on insurance that is secondary to Medicare. This item will reflect Medigap (private supplemental insurance), Medicaid of Maryland, and Blue Shield of Maryland.

Item 11

Q. How is this information different from Item 9?

A. Item 9 is information on supplementary insurance. Item 11 is information on Primary insurance (when item 11, 11a, 11b, and 11c are completed, an E.O.B. from the primary insurance should be attached to the claim).

Block 9 is for information on insurance that is secondary to Medicare, blocks 4, 7, and 11 are for information on insurance that is primary to Medicare.

Item 17

Q. When do I need the name of a referring physician on a claim?

A. When billing for

<i>Audiologist's services</i>	<i>Prosthetic/orthotic devices</i>
<i>Consultations</i>	<i>Radiology services</i>
<i>Durable medical equipment</i>	<i>Surgery (if no ref. physician, enter the word "none")</i>
<i>Laboratory services</i>	
<i>Machine tests</i>	
<i>Non-independent psychologist's services</i>	
<i>Occupational therapy</i>	
<i>Physical therapy</i>	

Item 24k

Q. What number should be used in this block?

- A. The **four digit individual number** assigned to a physician in a group practice should be used on each line item to identify the physician rendering the service. Do not use the physician's Unique Physician Identification Number (UPIN) in this block.*

Item 27

Q. If I am a participating physician, can I leave this space blank?

- A. A participating physician must always check yes. If this space is blank, "no" is assumed and the claim is denied.*

Item 33

Q. Do I put my number under Pin# or Grp# or both?

- A. Only **one** provider number should be listed in block 33. If you have a group provider number, list it under Grp#; if you have an individual provider number, list it under Pin#. This number is your carrier-assigned (Blue Shield) number. Medicare reviewed 60,000 claims in a one-week period; of the 60,000 claims reviewed, 10,151 had missing or incorrect provider numbers.*

OSHA Regulations

The Maryland Occupational Safety and Health (MOSH) Administration will be conducting training programs on the bloodborne pathogen standard. Although the seminars are free, pre-registration is required since space is limited. To register for seminars or to obtain copies of the standard, call (410) 333-4164.

Medical Assistance Program

Effective July 6, 1992, the Medical Care Operations Administration will implement changes to the Medical Assistance card. The changes are

- 1. The cards will not contain the dates of eligibility. Instead, the card will state "Call EVS." EVS must be called to determine if the recipient is eligible to receive services;*
- 2. The cards will **not** indicate whether the recipient is in a state or federal program. Therefore, providers will need to verify this information through EVS;*
- 3. The recipient's year of birth will appear on the card; and*
- 4. If a recipient is issued one or more duplicate cards, the DUP number on the card must match the number provided by EVS.*

Questions concerning the changes can be directed to Mr. Stephen Lanasa at (410) 225-5378 or Ms. Mary Dalton at (410) 225-5271.

Third Annual Conference on Addiction: Physician Health and Education

The Med Chi Physician Rehabilitation Committee is sponsoring a "Third Annual Conference on Addiction: Physician Health & Education" to be held on Saturday, November 21, 1992 at the Med Chi Faculty Building. The conference is scheduled to feature sessions on prescription drug abuse, litigation stress, and the effect of tobacco on psychotropic medications. Plenary sessions will address the following topics: What is addiction, patient placement criteria manual, identification and treatment of the substance abusing patient, and an update on how to help your patients stop smoking. For more information about the 1992 Med Chi Drug Conference, watch the *Executive Director's Newsletter*.

AMA Update

The following is an update from the Office of the General Counsel of the American Medical Association:

*"The Health Care Advisory Board, a Washington, D.C. organization that represents hospitals throughout the country, has issued a 250-page document entitled *Competitive Strategy: 10+ Long-Term Strategic Positions for Hospitals*. This*

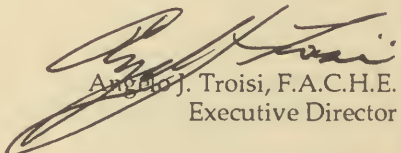
document describes strategies for hospitals to 'guarantee future revenue stream [and] improve margins in times of intense competition.' The document identifies gaining control of physicians as the 'top priority' survival strategy. The best way to control physicians, according to the document, is to employ them. As employers, hospitals can limit utilization, ensure referrals, and gain de facto control over payers. The advisory board concludes that although this strategy poses a significant risk of offending physicians, the issue for hospitals is whether the long-term potential warrants the risk: 'Advisory board answer: a resounding "yes."'

"The document also concludes that having physicians as partners is an excellent strategy for long-term survival, though not as desirable as employing physicians. As for a third strategy, selling hospitals to physicians, the advisory board concludes: 'hospitals not in dire financial straits may find abdicating 100 percent of control to physicians too extreme a measure to stomach.'

"Participating hospitals may obtain copies of this document by calling Latricia Beisler of the advisory board at 202-544-2700 or 202-467-1119 (phone mail)."

Maryland hospitals that are members of the Health Care Advisory Board include

Anne Arundel General Hospital - Annapolis
Baltimore County General Hospital - Randallstown
Bon Secours Health System, Inc. - Marriottsville
Church Hospital - Baltimore
Doctor's Community Hospital - Lanham
Franklin Square Hospital Center - Baltimore
Greater Baltimore Medical Center - Baltimore
Harbor Hospital Center - Baltimore
Helix Health System - Baltimore
Holy Cross Hospital of Silver Spring - Silver Spring
Howard County General Hospital - Columbia
Maryland General Hospital - Baltimore
Memorial Hospital at Easton Maryland - Easton
St. Agnes Hospital - Baltimore
The Sheppard & Enoch Pratt Hospital - Baltimore
Sinai Hospital of Baltimore - Baltimore
Suburban Hospital - Bethesda
Union Hospital of Cecil County - Elkton
Union Memorial Hospital - Baltimore
University of Maryland Medical System - Baltimore



Angelo J. Troisi, F.A.C.H.E.
Executive Director

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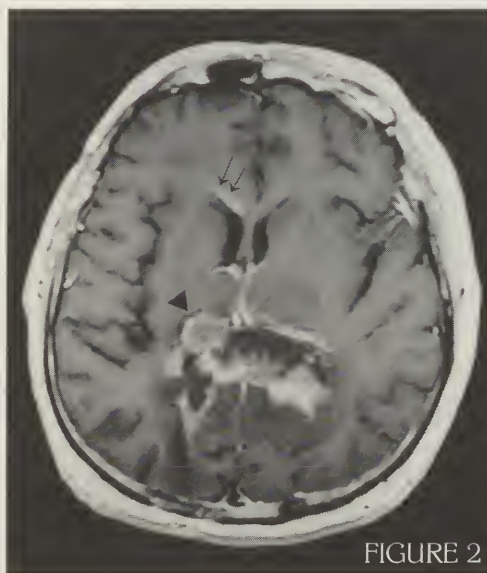
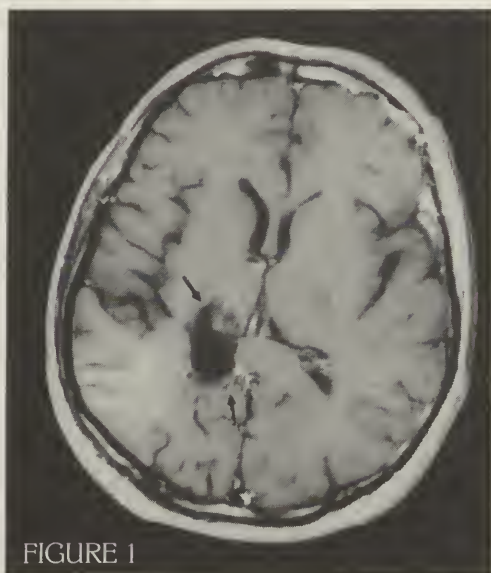
A 48 year old male 9 months post resection of glioblastoma multiforme and further treatment with radiation and chemotherapy with new onset left hemiparesis. Magnetic Resonance Imaging examinations at 3 and 6 month intervals revealed no recurrent tumor.

DIAGNOSIS: Recurrent glioblastoma multiforme right cerebral hemisphere with extension to the left hemisphere via the splenium of the corpus callosum.

Figure 1, post Gd DTPA enhanced T1 weighted image, 6 months post operative, demonstrates post surgical changes in the region of the right lateral ventricle, posterior thalamus and splenium of the corpus callosum (arrow).

Figure 2, same level as figure 1, 9 months post operative. In the interval, a contrast enhancing mass (arrowhead) has developed within the postero-rostral aspect of the right thalamus adjacent to the surgical bed. Contrast enhancement is also demonstrated throughout the splenium of the corpus callosum with extension into the periventricular occipital white matter. Also note the linear area of abnormal enhancement adjacent to the frontal horn of the right lateral ventricle (double arrow). Hypointensity within the white matter is consistent with vasogenic edema.

The marked interval change over the 3 month period including development of mass effect, vasogenic edema and contrast enhancement is consistent with recurrent glioblastoma multiforme which has extended into the left hemisphere via the corpus callosum. Other scans demonstrated a connection between the mass and the linear area of abnormal contrast enhancement adjacent to the frontal horn of the right lateral ventricle.



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Deeds, drugs, and dogs

In Greek mythology, there is the tale of Phryxus who, with his sister Helle, escaped from Thebes to Colchis by riding on the back of a winged ram—the ram with golden fleece. Unfortunately, Helle fell off and drowned in the water that was named for her—the Hellespont (Helle's sea)—and now renamed the Dardanelles, in honor of the Trojan city of Dardanus.

The heroic ram was subsequently killed, and its priceless coat hung in a sacred grove in Colchis. There it remained, guarded by a fierce dragon. It became the unenviable task of Jason and the crew of his famous ship *Argo*—known as the *Argonauts*—to steal the golden fleece and return it to Thebes. (The ship was built by a master builder named Argos, who named the vessel for himself.) *Nautes* is the Greek word for 'sailor', which stems from *naus* the word for 'ship'. We acquire all our *nautical* terms from this source, including the Greek word for seasickness—*nausia*. The Romans altered *naus* to Latin *navis*, from whence come our *naval* terms, including the *nave* of a church, which resembled the bow of a ship to someone long ago.

Colchis was an ancient country located south of the Caucasus Mountains in what is now the independent state of Georgia, formerly of the USSR. It was in the Caucasus Mountains that Zeus chained Prometheus for having given man fire. And it was in those craggy peaks that a human skull was once discovered.

The skull was prehistoric but quite well preserved, and it was sent to a scientist for careful study. His name was Johann Friedrich Blumenbach, the father of physical anthropology. He was the first man to suggest that humans should be evaluated through comparative anatomy. And he was first to classify human subspecies (or races) by anthropometric measurements of their skulls.

Based on those measurements, he suggested that there were five families of man: brown (Malaysians), red (American Indians), yellow (Mongols), black (Ethiopians), and white. The last he named *caucasian* because the most perfect example of a skull from this group came from the Caucasus Mountains.

Unfortunately, although Blumenbach did not intend it, his theories have subsidized centuries of bigots who have used it to advance the dogma of racial inferiority—from the ignominy of American slavery to the perfidy of the Holocaust. He also inadvertently provided physicians with their most consecrated pomposity: "A well-developed, well-nourished *caucasian*...." And lest we not forget, the tedious drone of the police: "Male *caucasian*, five foot eight, 165 pounds...."

In addition to providing the romantic backdrop for the adventure of the Golden Fleece, Colchis is famous for a native flower, a relative of the hyacinth and lily, which blooms in the fall. It is named for its place of origin—*Colchicum autumnale*. The plant conceals underground bulbs that produce a remarkable chemical. In 1763, von Storck promoted this chemical for the treatment of gout, calling it *colchicum*. Ben Franklin used it himself

WORD ROUNDS WORD ROUNDS WC

and introduced it into the United States. In 1820, it was purified, and the drug produced was called **colchicine**.

Early physicians believed that gout evolved as specific humors trickled out of the body, drop by drop. The Latin for drop is *gutta*, from which emerged **gout**. *Gutta* also gave us "gtts" as a prescriptive term.

In 1542, a professor of medicine at Tübingen, who was also a renowned botanist, described and named a lovely new plant. It grows from 18 to 60 inches in height and displays purple, bell-shaped flowers. The professor's name was Leonhard **Fuchs**, for whom the **fuchsia** was named (as well as the purple dye known as **basic fuchsin**). The plant which Fuchs himself named is called *Digitalis purpurea*.

Digitalis owes the genus name to its finger-like flowers (Latin *digitus* 'finger'). Its purple color gives us the species name. In fact, there are twenty-five to thirty *Digitalis* plants, each of which belong to the **foxglove** family. **Foxglove** derives from **fox** which stems from Old English 'folk', referring to the "little people," elves, and fairies; **glove** evolved from German *gloche* 'a bell'. Therefore, **foxglove** means fairy bells, implying the shape of the flowers, which are either bells or fingers, depending on your quixotic inclination.

Another plant, a small climbing shrub, flourishes in India. It is a member of the **dogbane** or **Apocynaceae** family, which includes the periwinkle and jasmine. In 1703, a French botanist named Plumier designated it *Rauwolfia serpentina* in honor of Leonhard **Rauwolf**, a sixteenth century German botanist.

In 1931, powdered whole root of this plant was first used by Indian physicians for patients with hypertension and psychiatric disorders. However, it wasn't until 1955 that Western physicians began to employ it. Shortly thereafter, a purified active drug was extracted from the whole root and named **reserpine**.

Dogbane is derived from the belief that the plant was poisonous to dogs (*bane*—Old English meaning 'to wound or kill'). As in, "it was the bane of my existence."). **Apocynaceae** derives from Latin *apo* 'away', and *cynicus* 'dog-like', which evolves from Greek *kynikos*, and, ultimately, from Greek *kyon* 'dog'. That is, something which injures or repels dogs.

The constellation Little Dipper or Ursa Minor was originally named *kynosoura* 'dog's tail'. The brightest star in that constellation is **Polaris**—the North Star—carefully observed by generations of wandering navigators searching for home. A **cynosure** started out as a dog's tail, but now is someone or something that is the center of attention.

And someone who is critical of a materialistic society is frequently called a **cynic**. He or she carries on a tradition instituted by **Diogenes** and his philosophic comrades who established the school of **Cynics**—an allusion to the dog-like snarl and the curled-up lips of its contemptuous practitioners.



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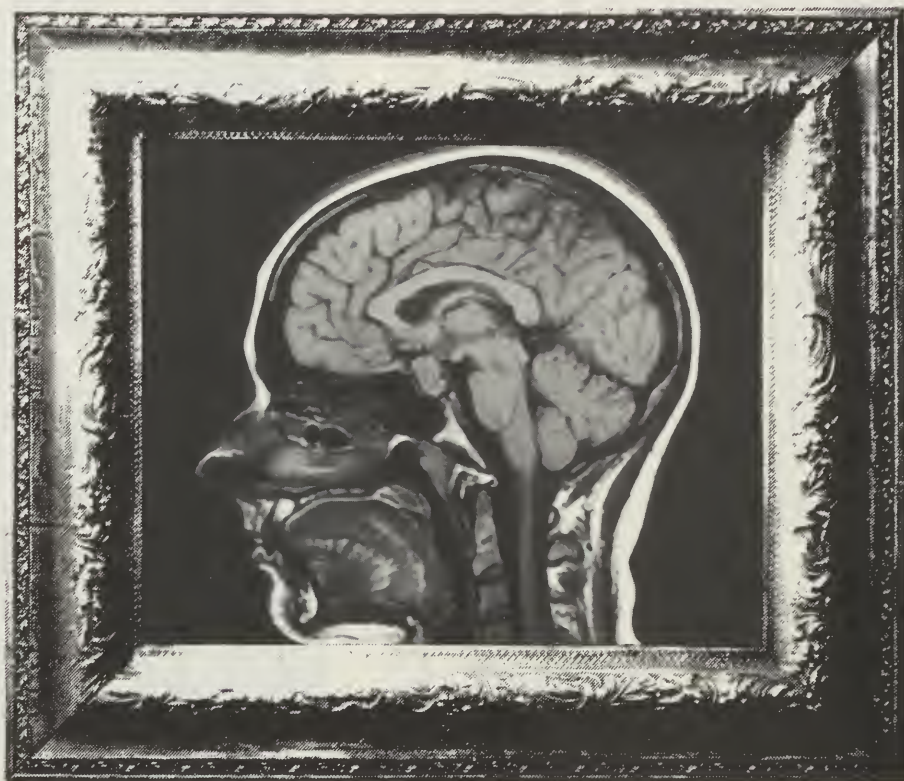
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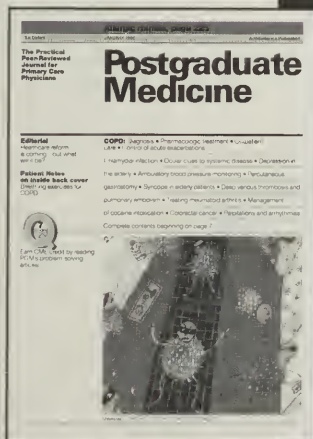
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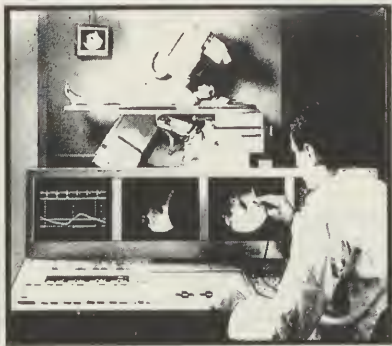
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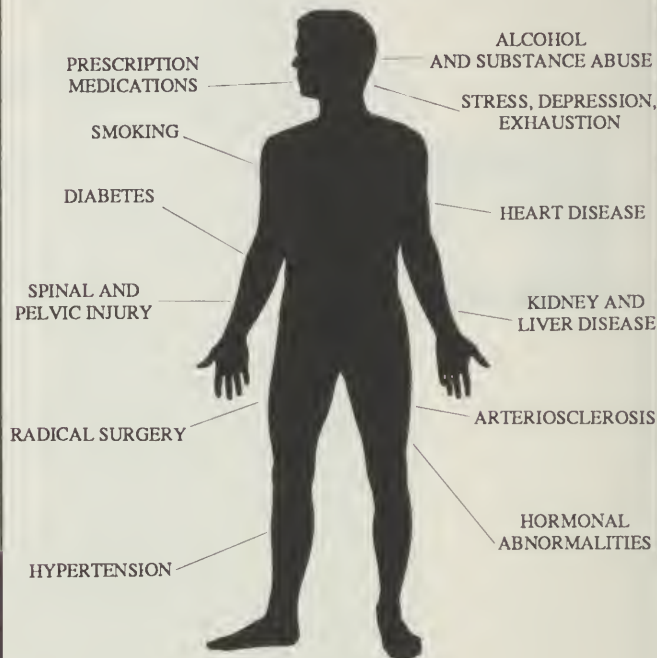


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A MEDICAL ECONOMICS PUBLICATION

Successfully defending a brain-damaged baby case is the courtroom equivalent of pitching a no-hitter. Because the "sympathy factor" can add millions to a jury's award, many insurance carriers would rather settle than fight.

Not so the P-I-E Mutual Insurance Co. of Cleveland, Ohio, and the 1-year-old law firm—Jacobian, Maynard, Tuschman & Kalur—that does all its defense work. In 21 brain-damaged baby cases it has defended for the doctor-owned company, its record is a remarkable 10-1-1, the last a hung jury. In 1988, its overall scorecard read 31 wins, 5 losses—all malpractice cases.

There's more to these numbers than luck. "It's even legal skill," adds JMT&K founding partner Aaron Jacobson, who was one of Ohio's leading plaintiffs' lawyers before he, Larry E. Rogers, Herbert S. Bell, M.D., and 20 other Cleveland doctors formed P-I-E in 1975.

"It's the concept behind the firm that makes it work. Physicians specialty panels review every lawsuit to decide whether the defendant deviated significantly from the standard of care. If he did, we pay. If he didn't, we defend. Makes no difference whether it's a \$5,000 or a \$5 million case. We label it No pay." That policy has resulted in a lot of cases being dropped. Perhaps more important, it's

DON'T YOU WISH THESE DEFENSE LAWYERS WERE YOURS?

This big, multistate firm rarely loses a case. But it's more than luck, or even legal skill, that's behind its enviable record.

By Howard Eisenberg

discouraged the filing of many other cases. Plaintiffs' attorneys have learned that we're fair negotiators when our doctor's in the wrong, but won't back down when he's right."

That approach pays off. According to the most recent report I've seen from the General Accounting Office, says Larry Rogers, P-I-E president and CEO, "in 1984, about 57 percent of medical malpractice claims were closed without payment."

Through 1988, we've closed an average of 78 percent of our cases without a dime changing hands. And it's my understanding that, without including defense costs, St. Paul Fire and Marine Insurance Co.'s 1988 average gross payout for cases closed in Ohio with payment was \$32,500. Our comparable figure was about \$10,000 below

there. That's partly why we can sell an OBG specialist in this an industrial state that ranks among the most litigious—\$1.2 million in coverage for just \$25,000."

The unique marriage of P-I-E and JMT&K has been so successful that the carrier has expanded into five other states: Indiana, Kentucky, Maryland, Missouri, and West Virginia. Where P-I-E goes, there goes JMT&K, with nine branch offices to date. The firm has 11 trial attorneys, and may well be the nation's largest devoted well-nigh exclusively to medical-malpractice defense.

Could the insurer-defender symbiosis, if duplicated by other doctor companies, make a significant contribution to reducing malpractice litigation nationwide? An up-close look at

how JMT&K operates may help to answer that question.

Every lawyer develops a medical specialty

"Our firm's lawyers read more medical books than law books," says P-I-E Vice President Gerard C. Digenorth, himself a veteran defense attorney. Robert Maynard explains, "New cases are discussed at our weekly staff meeting, so that every lawyer is familiar with every case. But we assign cases to our attorneys according to medical specialty. They're well versed in their fields, so they don't have to reinvent the wheel with each case."

Last year, the firm's OBG specialist, attorney Jerome S. Kahur, who had won 16 consecutive brain-damaged baby cases, faced one of his toughest challenges when he defended a GI

which attempted a midforceps delivery that ended in a Caesarean section and a severely brain-injured baby. Recalls Kahur, "I didn't think the doctor had caused the damage, but our position was weakened by the fact that he didn't have midforceps privileges. Based on that departure from the standard of care, our doctor panel voted to settle, and, since the hospital was also involved, a combined sum of \$1.5 million was offered. Plaintiffs turned us down flat."

"I wanted to depose the doctor, so they didn't have to reinvent the wheel with each case," says Kahur, "I was in the hospital pathologist's office with an order permitting me to view the mother's placental slides." Meconium staining had been charted, and Kahur had a hunch that fetal distress had begun long before the for-

The winning firm's four founders at Cleveland's 8th District Court of Appeals (from left): Jerome S. Kahur, Aaron Jacobson, James M. Tuschman, and Robert Maynard.

records were introduced at the trial end of the plaintiff's case. Meanwhile, I was in the no-win position of having to tell the jury, 'It couldn't have been the midforceps,' without offering them another reasonable brain damage theory."

Fortunately, the plaintiffs rested their case on a Friday afternoon, giving JMT&K time for a weekend rally. "Twenty minutes later," says Kahur, "I was in the hospital pathologist's office with an order permitting me to view the mother's placental slides." Meconium staining had been charted, and Kahur had a hunch that fetal distress had begun long before the for-

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In order to receive the special Med Chi group rate for your suite, you must call the Princess by **August 18, 1992**. A *1992 Semiannual Meeting Preliminary Program* with more detailed information about the meeting will be included in the August *MMJ*.

For more information about the Med Chi Semiannual Meeting, call Med Chi at 410-539-0872 or 1-800-492-1056.

Medical and Chirurgical Faculty of Maryland

1992 Semiannual Meeting

Friday-Sunday, September 18-20, 1992

Princess Royale Suite Hotel, Ocean City Maryland

Tentative Agenda

Friday, September 18

11:00 a.m. - 5:00 p.m. - Registration

11:00 a.m. - 5:00 p.m. - Exhibits

1:30 - 3:00 p.m. - Council Meeting

3:00 - 4:00 p.m. - Break - Visit the Exhibits**

4:00 - 6:00 p.m. - Continuing Medical Education

Topics to be discussed

Substance Abuse

Legal Aspects of Practice Management

6:00 - 7:00 p.m. - Welcome Reception for Med Chi Physicians

Saturday, September 19

7:30 a.m. - 5:00 p.m. - Registration

8:00 a.m. - 5:00 p.m. - Exhibits

8:00 - 10:00 a.m. - Reference Committees

Topics to be discussed

Self Referral

Other topics to be announced

8:00 - 10:00 a.m. - Continuing Medical Education

Topic to be discussed

Claims Abstracts - Learning from Experience

10:00 - 11:00 a.m. - Break - Visit the Exhibits**

11:00 a.m. - 12:30 p.m. - Continuing Medical Education

Topics to be discussed

Peer Review

Medical Management in Home Care

12:30 p.m. - 1:30 p.m. - Lunch on your own

1:30 - 3:30 p.m. - House of Delegates Meeting

Keynote Address - AMA Board of Trustees Chairman

Joseph T. Painter, M.D. (invited)

3:30 - 4:30 p.m. - Break - Visit the Exhibits**

4:30 - 6:00 p.m. - Continuing Medical Education

Topics to be discussed

Stress and the Physician

Sexual Harassment in the Physician's Office

Sunday, September 20

7:30 a.m. - 12:00 noon - Registration

8:30 - 10:00 a.m. - Continuing Medical Education

Topic to be discussed

Clinical Laboratory Improvement Act (CLIA)

10:30 a.m. - 12:00 noon - Continuing Medical Education

Topics to be discussed

OSHA/MOSH Regulations and Bloodborne Pathogens

Physician Rehabilitation

**VISIT THE EXHIBITS

Exhibits are an integral part of Med Chi's semiannual and annual meetings and are a valuable adjunct to the scientific program.

Med Chi has extended breaks during this meeting to allow physicians ample time to visit all the exhibitors. By visiting the exhibits, you will help ensure that Med Chi continues to receive the valuable income that allows us to offer the semiannual and annual meetings.

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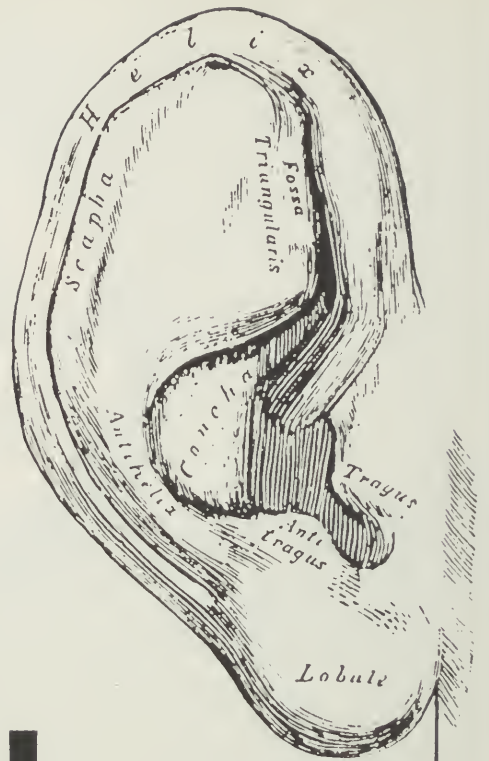
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University of Maryland Medical System: American medicine's first teaching facility reinvents the academic hospital

Stephen C. Schimpff, M.D. and Morton I. Rapoport, M.D.

The University of Maryland Medical School, established in 1807, focused on bedside teaching. This emphasis has continued and expanded through the growth of University Hospital and, ultimately, the University of Maryland Medical System, such that Maryland can now boast of a superb medical care system providing excellent medical education and research opportunities in a patient care setting.

Dr. Schimpff is executive vice president and Dr. Rapoport is president and chief executive officer of the University of Maryland Medical System, Baltimore, MD. Both are professors in the University of Maryland School of Medicine.

When the University of Maryland School of Medicine was established in 1807 as the nation's fifth medical school, most American medical schools placed more emphasis on classroom instruction than clinical education. At Maryland, the medical faculty focused on bedside teaching from the start, and in 1823, using their own personal resources, the professors built the Baltimore Infirmary (Figure 1) across from Davidge Hall on Lombard Street for \$14,109. This forerunner of University Hospital was the country's first hospital built specifically to teach medical students.

The hospital developed within this teaching mission through the nineteenth century and well into the twentieth. In 1850, the infirmary was enlarged to 150 beds, making it the largest hospital in Baltimore (Figure 2). In 1873, the state appropriated \$30,000 to build a new wing, where the Children's Department and the Department of Obstetrics were established. In 1897, a new hospital building was completed on the same site (Figure 3). Called University Hospital, the five-story building housed 200 beds. It was funded by \$70,000 in bonds sold by the professors, as well as \$20,000 in public contributions. In 1934, the hospital moved into a twelve-story tower at its present Greene Street site. This facility grew in 1953 with the addition of the Institute for Psychiatry and Human Behavior. Development of the early twelve-bed Shock Trauma Center in 1968 and construction of a thirteen-story addition to the hospital in 1973 rounded out the physical development of University Hospital for a time (Figure 4).

Not long after the last of these buildings was put into service, the 747-bed hospital, owned by the state and governed by the university, was confronted by a series of new challenges that forced a complete reexamination of its mission and organization. By 1980, the external environment for health care delivery was changing rapidly.¹ Hospitals were faced with the pressures of cost containment, technology advance-



Figure 1. The Baltimore Infirmary, forerunner of University Hospital, built in 1823.

ment, and competition for market share. At the same time, patients, their families, and payers were demanding improved quality and service.

University Hospital found itself poorly positioned to respond to these changing conditions. The hospital was only one of the professional education institutions of the University of Maryland at Baltimore (UMAB). Others were the Schools of Medicine, Nursing, Dentistry, Pharmacy, Social Work, and Law; the Maryland Institute for Emergency Medical Services Systems with its world renowned Shock Trauma Center; and the National Cancer Institute's Baltimore Cancer Research Center, nationally acclaimed for its clinical research. The hospital's physician staff—all faculty of the School of Medicine—received the major part of their salaries from the state and had little incentive to proactively build clinical practices. The charge to the faculty was excellence in education and research while providing appropriate patient care.



Figure 2. The Baltimore Infirmary, addition as of c1850.

Fundamentally, the University of Maryland Hospital existed to serve providers rather than patients.

Further, state ownership created a series of obstacles to effective management in a competitive health care marketplace. In 1980, University Hospital was approaching financial insolvency and was struggling with outmoded facilities and a declining insured patient base. The governor and legislature were increasingly concerned as financial losses of \$5 million to \$10 million per year were regularly absorbed by the state. Governance was through the Board of Regents, most members of which had no background in health care delivery. The hospital had little incentive for efficiency or improvement; revenues from patient care were simply returned to the state treasury, and capital funds were rarely made available.

While many in state government, on the Board of Regents, and in the university's administration struggled with the need to improve the functioning of University Hospital, the primary agent of change was T. Albert Farmer, who was appointed chancellor of UMAB in 1981. He proposed to create a governance mechanism distinct from the state and the university. The critical goals of separate governance became alignment of mission and vision with the changing health care environment, advocacy by a board chosen for its business acumen in health care delivery, flexibility to compete in the health care marketplace, and the ability to capitalize facilities and equipment improvements.

Initially, Farmer obtained approval to create the University of Maryland Medical System (UMMS) as a university program to include University Hospital, the Shock Trauma Center, and the University of Maryland Cancer Center—the latter created when the National Cancer Institute restructured its Baltimore-based program from an intramural to an extramural status. He appointed Dr. Morton I. Rapoport, previously senior associate dean of the School of Medicine, as chief executive officer to oversee the UMMS with a reporting relationship directly to the chancellor. Previously, the chief administrator of University Hospital reported to the dean of the School of Medicine.

The governor and many members of the legislature supported Farmer's initiative to disengage the state from direct involvement in health care delivery. However, it is important to note that Farmer's vision was not embraced by all concerned. The majority of the hospital's 4,000 employees did not favor a change, viewing it as a threat to their job security. The University of Maryland Medical System president and School of Medicine dean had concerns that an independent hospital board and management might not attend to the educational requirements of the School of Medicine. The leadership of the Shock Trauma Center also resisted restructuring, being



Figure 3. University Hospital, built in 1897.

concerned that new management focused on financial issues would threaten the high quality clinical program of the Shock Trauma Center. Finally, the hospital's local community was concerned that a hospital corporation would ignore the needs of the indigent or develop methods to reduce access.

The legislation to create a private University of Maryland Medical System took two years to accomplish. Tragically, Dr. Farmer died just after passage of the legislation in April 1984. The separate governance legislation was subject to many political compromises before passage, some of which created problems almost immediately. The ex officio members of the board, including the president and dean, were not given a vote. This increased the sense of disenfranchisement felt by the university faculty and complicated the early development of an appropriate medical school-UMMS partnership. In addition, the legislation made no provision to deal with the pressing capital needs of the UMMS. Fortunately, the UMMS quickly developed a track record of financial credibility and, as a result, both lending institutions and the state have been willing capital partners. Critical to early success was the gubernatorial appointment of an excellent board of directors chaired by Mr. Frank Gunther (who was also a member of the Board of Regents).

From the beginning, the UMMS leadership understood the organization's critical imperative—to reinvent the academic hospital and to reorder priorities from a provider-centered culture to a service culture that put the patient first. Service to patients would ultimately drive resources to enhance education and research.

Several years ago, the RAND Corporation was engaged by the Association of American Medical Colleges to determine the key factors that have allowed some academic medical centers to flourish in spite of harsh environments. In their 1987 report,

Managing for Survival, the authors indicated that to be successful, an academic medical center must obtain or create (1) a centralized, effective governance system; (2) a spirit of entrepreneurship at all levels of the organization; (3) incentives for faculty to generate revenue; (4) a methodology to allocate resources in a strategic manner; (5) a system to build the patient base; and (6) a willingness to actively pursue cost containment.²

Managing these factors has, indeed, been critical to UMMS's successful development as a private institution. With an effective governance system secured, UMMS's early actions focused on attaining fiscal and operational credibility along with quality improvements. Stephen C. Schimpff, M.D., previously the director of the University of Maryland Cancer Center, was recruited as executive vice-president and charged to deal with the critical operations, finance, and planning issues faced by UMMS.

Cost containment was recognized as a critical issue to be pursued. A unique Operations Improvement program modeled, in part, on the concept of "work redesign" and the Japanese concept of quality circles was initiated. Many health care practitioners believe that cost containment is associated with reductions in quality of care and of service. Thus, Operations Improvement was structured to address physician and nurse concerns regarding quality and efficiency. The Operations Improvement task forces identified \$8.2 million in cost savings without layoffs and with a positive change in work culture. The success of these activities reversed what had been multimillion dollar annual losses into consistent excesses of revenues over expenditures. Annual cash flow accelerated from less than \$3 million in 1983 to a projected \$15 million for fiscal year 1991. This improvement in fiscal stability led to credibility in the business, banking, and legis-



Figure 4. The University of Maryland Medical Center, core of the current University of Maryland at Baltimore campus.

lative communities, producing increased debt capacity critical to recapitalizing facilities and equipment and, ultimately, a bond rating of A/A+ by Moodys and Standard and Poor's, respectively.

While hospital management grappled with operational and financial improvements, the faculty of the School of Medicine took a bold step that further enhanced the shift to a patient-centered atmosphere. Historically, faculty physicians provided ambulatory care in their hospital-based offices or clinics. Recognizing that a large hospital is, at best, inconvenient and, at worst, intimidating to patients, the faculty renovated an historic loft building near the hospital as a professional office building. The University of Maryland Professional Building opened in 1986 and currently houses group practices in all adult specialties, as well as on-site laboratory, radiology, and radiation oncology services.

With enhanced fiscal strength developing, the next step in the summer of 1986 was initiation of a strategic plan of action to support the development of UMMS as a patient-centered, service-oriented organization. This effort (through a committee chaired by board member Roger C. Lipitz—later to become board chairman) initially focused on articulating the institutional vision, mission, goals, and values. The vision was to become a standard-setting academic hospital and an institution of distinction. The mission emphasized the primacy of patient care while fully supporting the education and research missions. The value system emphasized the importance of quality care, excellence in service, respect for the individual, quality in education and research, and the need for cost effectiveness.

Achievement of the vision clearly required an organization development process of several phases. Financial survival, the first stage, was secured by 1986. The remaining work included a strategic phase focused on strengthening management, strategic planning, and facilities renewal, followed by a qualitative phase focused on excellence in facilities, staff, and service quality. It is envisioned that these accomplishments, encompassing many of the principles set forth in the RAND study, will put UMMS on the path to regional distinction in the mid-to-late 1990s and lead to national distinction as a standard-setting academic medical center by the turn of the century.

In the strategic phase, an approach to resource allocation consistent with the strategic plan was developed. This was a critical step in that legitimate demands for facilities, personnel, and equipment vastly exceeded resources. Using the approved methodology for resource allocation, six tertiary clinical services were selected for development. Trauma, cardiac care, cancer care, neuro care, rehabilitation, and high-risk obstetrics/neonatology were identified for initial investment, with orthopaedics to follow. Additional investment priorities were enhancement of surgically-related activities and the reassessment of ambulatory care.

Consistent with these decisions, UMMS contracted with the State Department of Health and Mental Hygiene to operate the state-owned Montebello Rehabilitation Hospital (183 beds) for tertiary rehabilitation and acquired the James Lawrence Kernan Hospital, a 69-bed orthopaedic, sports medicine, and physical therapy facility. Together, these hospitals operate 38 percent of the rehabilitation beds in the state.

The strategic planning process also spawned a capital needs assessment that determined the need for at least \$200 million in equipment and facilities replacement to develop the defined strategic initiatives. A first phase of "survival" facility redevelopment was begun in 1984 to complete basic upgrades in the oldest of the hospital buildings and to initiate equipment replacement. This capital program evolved over six years to total \$130 million and was completed through a public/private partnership with the state. First phase improvements included the new Shock Trauma Center—a \$43 million facility funded by the state—and \$68 million of capital improvements funded by UMMS.

The facility renewal program has now entered a second phase. Rather than continuing to renovate constrained facilities, a new clinical tower and ambulatory center will be built, complemented by renovations to existing buildings (Figure 5). This second phase will require approximately \$210 million with success contingent upon continuation of the public/private partnership. UMMS will assume the major financial responsibility through debt and cash flow but will depend upon state funds and private philanthropy to assure that the entire project is completed. A major lead gift from the Homer Gudelsky Family Foundation has been a major catalyst for proceeding with one of the new facilities—the Homer Gudelsky Inpatient Tower (Figure 6).

With a solid strategic plan for moving forward, UMMS management and medical staff are now focused on the qualitative phase of organizational development. This has led to the



Figure 5. The medical center complex of the mid-1990s, including the new Homer Gudelsky Inpatient Tower and the new School of Medicine Health Sciences facility.



Figure 6. The Homer Gudelsky Inpatient Tower currently under construction.

formation of an active outreach program to physicians in the local community.

In addition, the UMMS has begun responding to the challenge described in the Greater Baltimore Committee Economic Vision Task Force's report: any vision for a future Baltimore economy must have a place for everyone—black and white, rich and poor, young and old, urban and suburban."³ The UMMS has already developed an active school partnership program with neighboring Frederick Douglas High School and a proactive minority business participation program that manages barriers to entry through community outreach and mentoring activities with minority contractors.

In addition, UMMS provides about \$28 million of uncompensated care annually—about 11.9 percent of gross revenues—in response to the community's concerns that the establishment of a medical system might create barriers to indigent patient care.

Change in an academic setting is always difficult. The changes required of the medical system and its physicians have been sweeping and rapid but necessary to create an academic hospital equipped to survive and thrive into the twenty-first century. The University of Maryland Medical System has been successful since its formation as a private corporation separate from state ownership and university governance in 1984 and will continue to distinguish itself by creating a high quality medical care system that provides medical education and research opportunities in a patient care setting—a fitting heritage for America's first teaching hospital.

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Acknowledgment

Ms. Lisa Akchin assisted in development of this article.

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Interferon therapy for multiple sclerosis

Kenneth P. Johnson, M.D. and Hillel S. Panitch, M.D.

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Laboratory findings that suppressor cell function is improved with beta interferon therapy and that gamma interferon activity is inhibited by beta interferon provide support for the hypothesis that beta interferon will have a significant therapeutic effect on relapse rates in multiple sclerosis.

Multiple sclerosis (MS) is a major crippling disease primarily affecting young adults. It occurs most often in persons of northern European descent and affects women approximately 65 percent of the time. Two major disease patterns or phases are recognized: Relapsing-remitting (R-R), in which there is the abrupt appearance of neurologic dysfunction followed by slow improvement, and chronic-progressive, characterized by increasing neurologic disability at a slower tempo without remission of symptoms. The disease course is highly variable in individual patients. MS is classified as an autoimmune condition that is thought to depend on three basic principles: a genetic predisposition, an initiating event in childhood or young adult life that sensitizes the immune system, and triggering factors that activate the immune system to attack specific antigens in central nervous system (CNS) myelin. Neurologic dysfunction results from repeated or continuous damage to white matter of the brain and spinal cord.

The disease can be diagnosed with some assurance. First, by recognizing the clinical pattern; second, by observing multiple CNS white matter lesions by magnetic resonance imaging (MRI), often enhanced with gadolinium; and, third, by detecting characteristic qualitative and quantitative immunoglobulin changes in cerebrospinal fluid.

Current therapies for MS include ACTH (adrenocorticotropic hormone) and various synthetic corticosteroid preparations. Potent immunosuppressive drugs, such as cyclophosphamide, cyclosporine, and azathioprine, have been evaluated during the last decade, but in controlled trials have not been found to be of significant benefit. An ideal therapeutic agent would be nontoxic enough to be used in the early stages of disease, be convenient for long-term use, and have no late sequelae.

Early studies with alpha interferon

In 1979, evidence was presented suggesting that MS patients were deficient in interferon activity.¹ This finding suggested that interferons

may be of therapeutic benefit. So, in 1979, a small study was undertaken at two centers in California—Scripps Clinic in La Jolla and the University of California, San Francisco—in which the authors participated (Table). Twenty-four R-R MS patients were injected daily subcutaneously with 5 million units of natural alpha interferon or a placebo for six months, allowed a period of rest, and then injected with the alternate preparation for the same period of time. Analysis showed that there was a decrease in numbers of relapses during interferon treatment; however, the side effects of fever, malaise, and fatigue were significant.²

By 1981, when the first recombinant interferon products were available for clinical study, the authors had relocated to the University of Maryland at Baltimore. A study of recombinant alpha-2 interferon was undertaken at the University of Maryland School of Medicine and at Temple University in Philadelphia. One hundred patients were randomized and injected three times a week with 2 million units of recombinant alpha interferon or placebo for one year. Side effects at this much reduced dose were very low; however, a large placebo effect was noted, making it impossible to determine if the interferon therapy was substantially better than placebo.³ Interestingly, some immunologic changes in peripheral blood lymphocytes were recognized in the placebo group, suggesting that the effect was immunologic as well as psychologic.⁴

The gamma interferon trial

The authors were approached in 1984 about testing gamma interferon for therapeutic use in MS. Gamma interferon is known to be functionally different from either alpha or beta interferon, with numerous immunologic effects that could be potentially detrimental to the course of MS. With considerable caution, a small pilot study was designed in which three dose levels of gamma interferon—1 mcg, 100 mcg, or 1,000

mcg—were injected intravenously two times weekly for one month. Eighteen young, R-R MS patients were enrolled. During the month of therapy, seven of the eighteen patients developed exacerbations of MS indicating that gamma interferon was a potent stimulant of new immunologic activity.⁵ This finding has stimulated great interest and considerable research into the role of gamma interferon in MS and other autoimmune diseases. Gamma interferon is known to enhance class II histocompatibility antigen expression, not only on monocytes and macrophages, but also on CNS cells, including astrocytes, microglia, and endothelial cells. In the gamma interferon trial, it was observed that class II expression on peripheral blood monocytes was, in fact, enhanced.⁶

Epidemiological studies⁷ reported at about the same time as the trial of gamma interferon, indicated that common febrile events, primarily respiratory infections, often were followed by new MS relapses. Thus, the hypothesis was developed that common infectious stimulants of immunologic activity may cause MS relapses by mechanisms that include activation of gamma interferon and its subsequent effects. These studies also suggested that if one could control or inhibit gamma interferon synthesis and activity, a beneficial effect on the course of MS might be achieved.

Studies of beta interferon therapy

Concurrent with the studies of alpha and gamma interferon being performed at the University of Maryland, other workers at the State University of New York in Buffalo had shown that natural beta interferon injected intrathecally had a therapeutic benefit on the relapse rate in MS.⁸ These studies have not been pursued further, however, because of the inconvenience and potential adverse effects of repeated injections of substances into the subarachnoid space.

In 1986, the first study of systemic recombinant beta interferon in MS was initiated at the University of Maryland

Table—Principal clinical trials of interferons in MS

Investigator	Interferon	Dose	Route of Rx	Duration	No. of patients	Clinical type	Design	Result
Jacobs et al	Natural β	1/week, then 1/month	IT	6 months	69	RR	DB,PC	Fewer attacks IFN group
Knobler et al	Natural α	5 MU/day	SC	6 months	24	RR,RP	DB,PC Crossover	Fewer attacks in RR group, no effect in RP
Camenga et al	r α_2	2 MU 3x/week	SC	12 months	98	RR,RP, CP	DB,PC	No difference between IFN and placebo
Panitch et al	r γ	15,000 U to 15 MU 2x/week	IV	1 month	18	RR	SB	Increased attacks during treatment
Pilot Betaseron study	r β	Various doses, then 45 MU 3x/week	SC	36 months	30	RR	DB,PC	Lower attack rate in IFN group
Multicenter Betaseron	r β	45 MU or 9 MU every other day	SC	24 months	330	RR	DB,PC	In progress

IFN = interferon; MU = million units; IT = intrathecal; IV = intravenous; SC = subcutaneous; RR = relapsing-remitting; RP = relapsing-progressive; CP = chronic-progressive; CS = chronic-stable; SB = single-blind; DB = double-blind; PC = placebo-controlled; r = recombinant.

in collaboration with investigators at Temple University and Thomas Jefferson University in Philadelphia. An initial pilot trial was undertaken to determine the proper dose and to detect potential toxic effects of beta interferon. Thirty patients were randomized to placebo—4.5, 22.5, 45, or 90 million units of beta interferon injected subcutaneously three times a week. Within six months, it was apparent that beta interferon did not stimulate new MS disease activity. Patients receiving 90 million units were, in fact, free of relapses; however, they also experienced intolerable side effects. There appeared to be a substantial reduction in relapses in those receiving 45 million units, although patients receiving lower doses or placebo continued to experience frequent relapses. Therefore, all patients were changed to the 45 million unit dose injected three times a week. This pilot study has now been continued for over five years; no long-term adverse effects have been observed, the majority of patients remain on therapy, and most have tended to have very few MS attacks.⁹ Because of the small numbers, however, no conclusive evidence of efficacy was documented.

On the basis of these results, a large multicenter study, involving 360 patients enrolled at twelve university MS centers in the United States and Canada, was undertaken in 1987. Patients were randomized to one of three groups: placebo, 9 million units, or 45 million units of beta interferon self-injected subcutaneously every other day for a period of two years. A decrease in the clinical relapse rate was accepted as the primary end point for efficacy. The final patient completed the two years of observation on July 30, 1991. The search for efficacy was enhanced by yearly cerebral MRI scans for all patients and by frequent MRI scans (every six weeks) at the University of British Columbia, Vancouver. The results of this large study are currently being analyzed in preparation for submission to the Food and Drug Administration (FDA) in 1992.

Several investigative groups participating in this multicenter trial have also undertaken immunologic studies of the patients involved. At the University of Maryland, we have observed a close relationship between common febrile events and new MS disease activity in a linkage that is much stronger than had been detected in earlier studies. It is hoped that it will be possible to determine the type of infection stimulating MS activity and, perhaps, what effect interferon therapy has on infection rates due to common viruses. At the University of Chicago, investigators showed that suppressor cell function, which is known to be deficient in MS, was improved with beta interferon therapy.¹⁰ Perhaps most interesting, several laboratories, including our own, showed that beta interferon inhibits gamma interferon synthesis and effects *in vitro* in a dose-related fashion.

Conclusions

Over the last twelve years, highly purified recombinant preparations of all three human interferons have become available, and all three have been evaluated for therapeutic

benefit in early MS at the University of Maryland Department of Neurology. The observation that exposure of MS patients to gamma interferon led to recurrent disease activity was a major advance in understanding the pathogenesis of MS and has pointed to significant new directions for research in the disease. Laboratory findings indicating that suppressor cell function is improved with beta interferon therapy and that gamma interferon activity is inhibited by beta interferon provide scientific underpinnings for the hypothesis that beta interferon will have a significant therapeutic effect on relapse rates in MS. Both the pilot study and the large multicenter investigation demonstrate that frequent injections of high dose beta interferon have little risk and can be self-administered by MS patients on a long-term basis. If the analysis of the multicenter trial data indicates significant efficacy and these findings are accepted by the FDA for licensure, beta interferon will become the first new agent to be approved for therapy of MS since ACTH and corticosteroids were found to be beneficial over twenty years ago.

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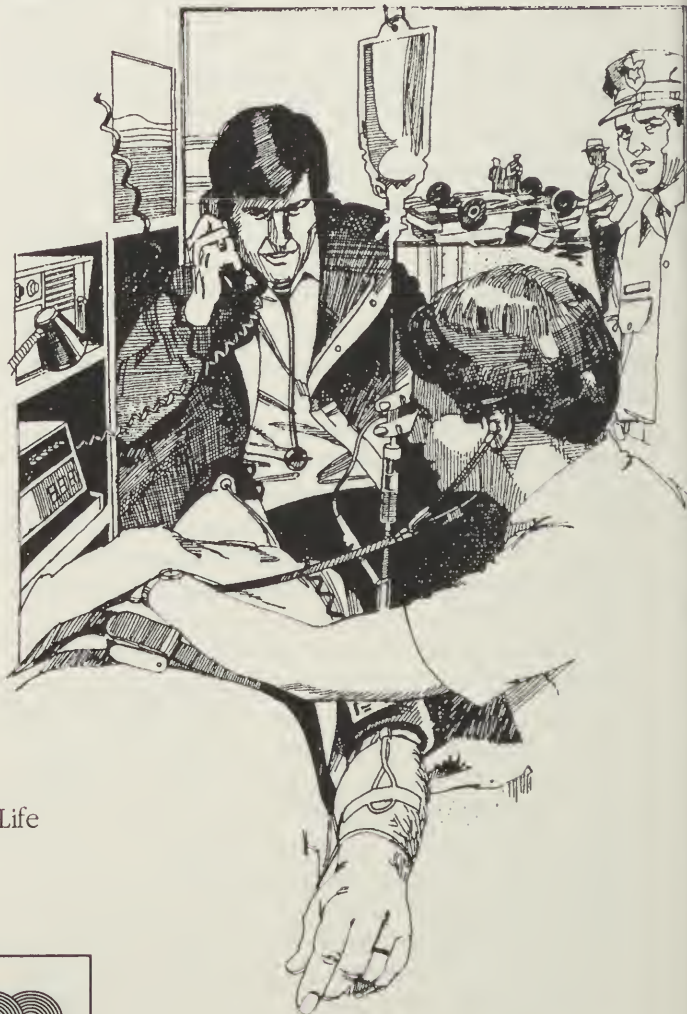
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Laparoscopic general surgery: Current status and future prospects

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The capability of performing major abdominal surgery while avoiding a large abdominal incision has clear benefits for patient care.

Laparoscopic cholecystectomy can reduce hospital stays and the length of the recovery period, as well as decrease postoperative pain, diminish scarring, and provide significant cost savings.

The recent widespread introduction of laparoscopic cholecystectomy into clinical practice has demonstrated the enormous benefits of laparoscopic surgery. The capability of performing major abdominal surgery while avoiding a large abdominal incision has clear implications for patient care and the future of general surgery. Following laparoscopic cholecystectomy, hospital stay is reduced from one week to less than twenty-four hours, and the recovery period is reduced from three to six weeks to an average of five days.^{1,2} Other advantages of laparoscopic surgery include decreased postoperative pain, diminished abdominal scarring, and a substantial savings in health care costs (estimated to be in the billions of dollars per year).

Laparoscopic cholecystectomy

In 1989, a clinical program in laparoscopic surgery was established at the University of Maryland Medical Center.³ Since that time, over 500 laparoscopic cholecystectomies have been performed at our institution. The technique of laparoscopic cholecystectomy has been previously described in detail.⁴ The operative principles are quite similar to open cholecystectomy in that the entire gallbladder is removed intact from the abdominal cavity. The laparoscope, however, has allowed surgeons the ability to identify safely the important anatomic structures (**Figure 1**), without the need for a large subcostal or midline incision. Operative visualization is magnified through the laparoscope and the resultant image is channeled to two large video monitors placed near the operating room table (**Figure 2**). The advantages of a laparoscopic approach have now been clearly documented in the literature. The experience with the first 375 cases at the University of Maryland has recently been published.¹ The gallbladder can be successfully removed in 95 percent of cases, and the overall rate of morbidity and mortality is 3.6 percent and 0.3 percent,

respectively. The average hospital stay is 1.3 days, and the average return to normal activity is one week. This is in distinct contrast to the usual results seen following open cholecystectomy.⁵ (Due to space limitations, as well as the fact that this paper focuses on the future of laparoscopic

surgery and, as such, deals with many of the newer advanced procedures, we have not delineated the specific indications for this surgery. In addition, laparoscopic cholecystectomy is currently the procedure of choice at our institution, as well as many others in the United States. As such, virtually all patients with symptomatic gallbladder disease, even those presenting on an emergent basis, are candidates for an initial laparoscopic approach.)

Evolution of laparoscopic general surgery

Although initial results with laparoscopic cholecystectomy have been encouraging, concern has been raised over the issue of proper credentialing in laparoscopic general surgery. Shortly after the beginning of our clinical laparoscopic program, a formal training program in laparoscopic surgery was established at the University of Maryland Medical Center.⁶ Guidelines were issued regarding the steps to take to acquire proper training in laparoscopic cholecystectomy. Similar guidelines have also been adopted by numerous other institutions and professional societies. As more and more surgical procedures are converted to a laparoscopic approach, such issues will be of great interest to many surgeons.

Advanced laparoscopic procedures aside, the most important developments to date have centered around new instrumentation and technology. Laparoscopic instruments that perform similar functions to conventional operating tools are now becoming available on a routine basis. Curved dissecting instruments, Metzenbaum scissors, atraumatic graspers, and automatic clip applicators have greatly increased the surgeon's ability to perform more complex maneuvers under laparoscopic guidance. Laparoscopic video technology also has improved over the last several years. "One-chip" cameras are slowly being replaced by "three-chip" cameras that provide improved resolution and color imaging. Currently, the University of Maryland is in the process of evaluating the safety and efficacy of a flexible laparoscope (Fujinon, Inc., Wayne, New Jersey) for future Food and Drug Administration (FDA) review. It is anticipated that the same advantages of flexible gastrointestinal endoscopy over rigid endoscopy will be realized with flexible laparoscopy.

The last several years have also wit-

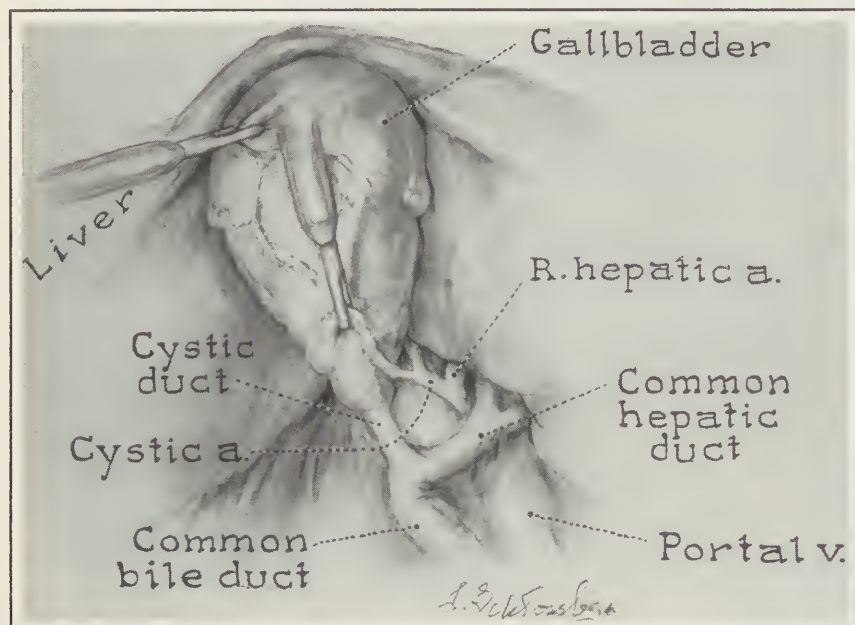


Figure 1. View of the gallbladder, cystic duct, cystic artery, and common bile duct during laparoscopic cholecystectomy. (Reprinted with permission from Zucker KA. Laparoscopic guided cholecystectomy with electrocautery dissection. In: Zucker KA, Bailey RW, Reddick EJ, eds. *Surgical Laparoscopy*. St. Louis: Quality Medical Publishing, Inc. 1991; 159.)

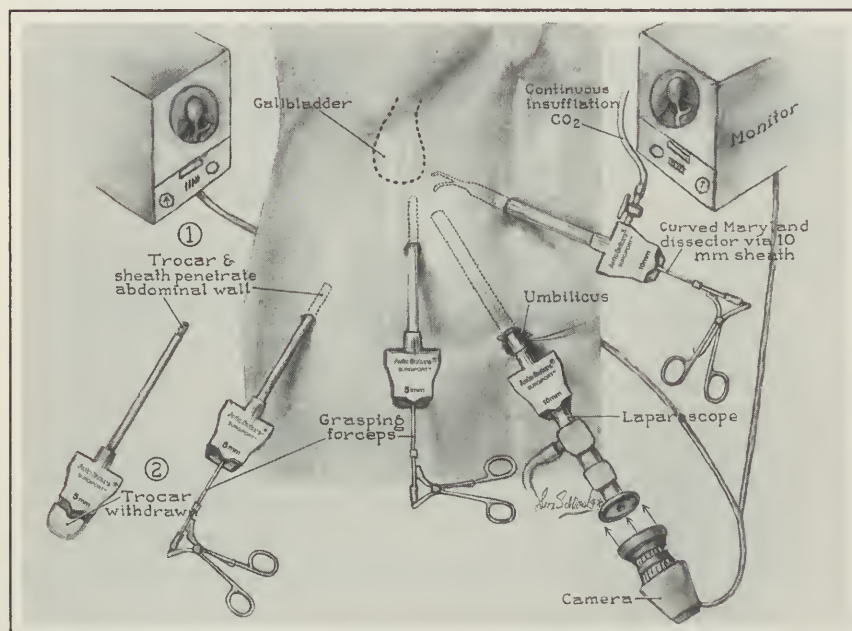


Figure 2. Operative visualization is magnified through the laparoscope and the resultant image is channeled to two large video monitors placed near the operating room table. In this fashion, the entire operating team (surgeon, assistant, scrub nurse, and circulating nurse) can monitor and participate in the surgical procedure.

nessed a surge of journal publications as well as formal texts on surgical laparoscopy.⁷ New journals, dedicated to this new field of laparoscopic general surgery, have been created within the last two years and are meeting with overwhelming success.

Advanced laparoscopic general surgical procedures

The explosive response of the medical community to laparoscopic cholecystectomy has sparked investigation into other general surgical procedures that could be performed under laparoscopic guidance (Table). Already, laparoscopic vagotomy for the treatment of symptomatic peptic ulcer disease, small and large bowel resection for the treatment of intestinal obstruction and malignancy, hernia repair, and appendectomy for acute appendicitis have been performed in our division of gastrointestinal surgery.⁸ Other centers have also reported success with such advanced laparoscopic procedures.⁹⁻¹² In addition, the advantages of laparoscopic technology are by no means limited to general surgery. Laparoscopic pelvic lymphadenectomy for the staging of prostate and bladder cancer¹³ has now been successfully performed in over twenty patients with excellent results. Similar approaches have also been successfully employed for the diagnosis and treatment of numerous pulmonary/mediastinal conditions that would have otherwise necessitated open thoracotomy.

One of the most important questions yet to be answered is whether a laparoscopic approach will offer distinct advantages over the current results with open procedures. It is difficult to imagine how one can improve on outpatient hernia repair under local anesthesia. It has been to many surgeons' surprise however, to discover that there are distinct benefits from a laparoscopic operation. For example, patients undergoing laparoscopic hernia repair can still be discharged the same day with acceptable results. The patients, however, experience little to no discomfort during the immediate postoperative period and can return to full, normal activity within one to three days. This is in distinct contrast to current results with conventional herniorrhaphy.

It is anticipated that by the end of the next decade as much as 40 to 60 percent of general surgical procedures will be performed under laparoscopic guidance, quite similar to the increase in laparoscopic gynecologic surgery witnessed over the last ten to fifteen years. The advantages of minimally

invasive approaches to medical conditions have been recognized for many years. The development of coronary angioplasty, transurethral resection of the prostate, therapeutic gastrointestinal and biliary endoscopy, and laparoscopic gynecologic surgery attest to this fact. The revolution has only just begun in general surgery.

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Table

Advanced laparoscopic surgery

Laparoscopic biliary tract surgery
Laparoscopic appendectomy
Laparoscopic herniorrhaphy
Laparoscopic vagotomy
Laparoscopic pelvic lymphadenectomy
Laparoscopic intestinal resection
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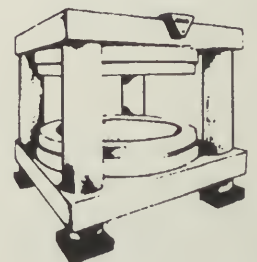
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Aging and humoral immunity

Edmond A. Goidl, Ph.D.; Jan Cerny, M.D., Ph.D.;
Garnett Kelsoe, D.Sc.; and Dan H. Schulze, Ph.D.

If human antibody responses undergo molecular shifts similar to those identified in mice, the appropriate immunization strategy for the elderly would be a passive administration of the protective antibody from young donors rather than an attempt to boost the individual's own response with a more potent vaccine, because the shifted immune system can no longer make the right kind of antibody.

From the Department of Microbiology and Immunology, University of Maryland School of Medicine, where Drs. Goidl, Kelsoe, and Schulze are associate professors of microbiology and immunology, and Dr. Cerny is professor and chairman. Reprints: Edmond A. Goidl, Ph.D., Department of Microbiology and Immunology, University of Maryland School of Medicine, 655 West Baltimore Street, Baltimore, MD 21201

Statements recently published in the foreword to *Longevity, Senescence and the Genome* demonstrate the shortcomings of our understanding of the aging process.¹ Caleb Finch poses such questions as: Is senescence obligatory? Are there intrinsic limitations in the life history pattern of man? What, if any, are the genetic and environmental contributions to senescence? That these basic questions still exist suggest that novel approaches and techniques need to be developed in the study of aging.

In this report, we present an overview of new ideas and developments in the field of aging and the immune response, with a particular emphasis on research by the members of the Immunology and Aging Group of the School of Medicine at the University of Maryland. The common thread that runs through the work focuses on the age-related change of antibody responses. The new concepts described here have been built primarily using laboratory animal, experimental model systems; however, they are being supported by studies on humans.

Immune dysfunction is one of the hallmarks of aging in both humans and experimental animals.²⁻¹² This dysfunction puts the aging population at risk of fatal infections, autoimmune diseases, and other chronic illnesses. By gaining insight into the mechanisms of age-related immunological changes, we may develop strategies for immune manipulation and prevention of premature death.

The antibody responses of aged individuals tend to be less robust than younger adults, but this is not a general rule. In some instances, antibodies for specific antigens are produced in high amounts by the aged, but the antibody molecules appear to be structurally and functionally different. This suggests that the aging immune machinery is not simply slowing down; rather, the molecular and cellular processes become more regulated

(or disregulated) differently. Before discussing these novel findings, we should set the stage with a brief description of the antibody system.

The cells that are responsible for the production of antibodies are the B lymphocytes. Upon stimulation with antigen (i.e., pathogen), B cells bearing the specific immunoglobulin begin to synthesize large quantities of messenger ribonucleic acid (mRNA) and antibodies. The immunoglobulin molecules are secreted into body fluids to become circulating antibodies. It has been estimated that any individual can produce as many as 10^8 different antibodies.¹³ However, each B cell can produce antibody with only one unique specificity. This extensive repertoire is generated by rearrangements of deoxyribonucleic acid (DNA) sequences¹⁴; five distinct gene segments are randomly selected from a pool of several hundred, and recombine to encode a specific antibody molecule. In this gene shuffling, additional diversity is obtained by the imperfect joining of the DNA sequences. Finally, the antibody diversity is hugely increased by a unique adaptive mechanism of "affinity maturation." It is based on immunoglobulin gene(s) mutations that take place only in the antigen-stimulated B cells. The genetic mutations that have higher affinity—stronger binding—for the invading antigen are then selected for continued antibody production.

B-cell populations have a remarkably rapid turnover. The half-life of B cells is short, and new cells are continually being produced in the bone marrow. The new functionally competent B cells are generated from pluripotent stem-cells (PSC) that are called pluripotent because they give rise to all cells in the blood and lymphatics; just a few PSC are capable of repopulating the whole immune system.¹⁵⁻¹⁷ There does exist a subpopulation of B cells that can become long-lived as a consequence of an antigen encounter. These "memory" B cells afford the individual the ability to respond with great rapidity upon reintroduction of the antigen. There exists some controversy concerning specific markers for these memory cells.

The processes of antibody response—from the generation of B cells to affinity maturation—is regulated by an altogether different set of lymphocytes: T cells. It has been well established that T-cell functions also change significantly in the aged.¹¹⁻¹³ Because of the interaction between T cells (the regulators) and B cells (the producers), the alteration of antibody responses in the aged may be linked to either one cell population or both. It is, therefore, important to separate the effects of T cells from age-related changes that are intrinsic to B cells.

The bone marrow in aging

Since the bone marrow is the source of the erythroid, myeloid, and lymphoid cell lineages including the B cells, any age-related change in the bone marrow functions could have significant effects on the antibody response. Briefly, studies on experimental animals have not revealed any gross alteration in the stem-cell (PSC) function at advanced age. The aged PSC appear to be fully competent to proliferate, repopu-

late the lymphoid system, and generate mature B cells. The frequency of B cells specific for particular antigens may change with age. Surprisingly, however, aging does not seem to affect the B cells for different antigens in the same manner. For example, the B-cell frequency for phosphorylcholine (PC) antigen is increased in the aged,¹⁸ while the precursor frequency for 2,4-dinitrophenyl (DNP) antigen¹⁹ is decreased. For the response to the PR8 influenza antigen, no change in precursor frequency is seen with aging.²⁰ Likewise, a survey of seven protein antigens, including molecules such as insulin and myoglobin, which are potential targets for autoimmune antibodies, demonstrated little difference between the B-cell frequencies of young and aged mice (Garnett Kelsoe, D.Sc., unpublished observations). Therefore, no simple pattern of age-associated change in B-cell precursor frequencies has emerged.

It may be that there are subtle changes in the function of aged bone marrow that would be detectable with more refined methods. Ongoing work in our group (Dan H. Schulze, Ph.D. and collaborators) attempts to dissect the early stages of B-cell differentiation using a cytotoxic drug—hydroxyurea (HU)—that kills dividing cells. Brief treatment with this compound permits the identification of newly arising cells in the bone marrow by using cell surface markers to identify different subpopulations. Recently, it was observed that the bone marrow of aged mice shows a dramatic reduction in its ability to produce new B cells. Experiments are underway to determine if this is a characteristic of the microenvironment of the bone marrow or of the stem-cell population of aged mice.

Other experiments suggest that the development of B cells from bone marrow is strongly influenced by the age of the regulator lymphocytes from the T-cell lineage. In these studies, the immune system of lethally-irradiated mice was reconstituted from the bone marrow in the presence of transfused T cells from young or aged donors. It was found that T cells caused the immune response to become young-like if the animals had received T cells from young donors, or aged-like if they received T cells from aged donors.⁵

Magnitude of antibody responses

An early notion that the vigor of antibody responses is generally diminished at advanced age is clearly an oversimplification. It appears, instead, that the aging immune system is a mosaic in which the responses to some antigens decrease while other responses remain either undiminished or enhanced. Moreover, the studies on inbred mice suggest that the genetic make-up of the host may influence this process.

The antibody responses to protein antigens tend to be profoundly diminished in aged animals and humans.⁷⁻¹¹ For example, the antibody response against DNP coupled to bovine gamma globulin is decreased almost six-fold in aged mice of the BALB/c and C57BL/6 strains when compared with the young.²¹ Aged mice of other strains, however, demonstrated much less variation of antibody response to this antigen.²¹ It is noteworthy that the responses to protein antigens are strongly dependent on the regulation by T cells,

suggesting that the decreases of antibody levels may be related to a malfunction of the aged T cells. This view is consistent with the findings of undiminished,^{22,23} or even increased, responses of aged animals to more complex antigens that contain a polysaccharide moiety, for such responses are generally less dependent on the T-cell help. We have recently shown that when aged BALB/c mice are immunized with *Streptococcus pneumoniae*,²⁴ their anti-body response to the cell-wall polysaccharide antigenic determinant—phosphorylcholine (PC)—is comparable and sometimes higher than that obtained in young controls. In contrast, the response to PC by the aged C57BL/6 mouse follows the general pattern of age-related decreases in magnitude. Therefore, the changes seen in aging are modulated, in part, by the genetic background of the animal and, since the aged BALB/c mouse shows a decreased response to TNP-Ficoll but not to PC, by the antigen itself.²⁵ These results imply that certain aged individuals maintain a strong antibody response to a given antigen while others do not, depending on their genetic makeup.

Immunosenescence can also be seen at the level of total serum immunoglobulins in normal, unimmunized animals. In recent studies, serum concentrations of several immunoglobulin isotypes and subclasses have been determined in inbred strains of mice at different ages. There is a gradual age-related increase of serum immunoglobulin concentration, although one can identify distinct patterns among different inbred strains of mice.²⁶ These distinct patterns may be related to genetic susceptibility to certain diseases, to environmental conditions, and to exposure to microbial agents. Skewing to certain isotypes of antibodies has been reported in responses to proteins, carbohydrates, and viral and parasitic infections.²⁷

Although it appears that many of the age-associated deficits of antibody responses reflect T-cell dysfunctions, some lesions intrinsic to B cells do exist. We have demonstrated (Jan Cerny) that *in vitro*, even in the presence of supporting T cells from young mice, aged splenic B cells have a reduced capacity to proliferate and differentiate following exposure to bacterial lipopolysaccharide (LPS)—a B-cell mitogen. This deficit is manifested at the level of individual B-cell clones as an increase in mitotic cycle time and a reduction in division numbers. The numbers of proliferating cells differentiating into plasmacytes is also reduced, and aged plasmacytes contain about 20 percent less mRNA—an indicator of immunoglobulin synthesis—than do young controls. Interestingly, addition of a second mitogen (dextran sulfate) to cultures of LPS-stimulated B cells from the aged overcomes these proliferative and differentiative deficits. The mechanism of this amelioration is unknown, but the finding implies that B-cell defects in the aged may be amenable to therapy.

Antibodies that detect self-determinants

A curious aspect of aging is the increased production of antibody against various self-structures, such as DNA and red blood cells, in both humans and laboratory mice.^{23,25} This is

not generally associated with clinical symptoms,²⁸ suggesting that the age-related autoantibodies are mostly nonpathogenic. It may be that the appearance of these antibodies reflects subtle alterations in T-cell regulation of self-reactive B-cell clones. An alternative hypothesis is that the autoreactivity reflects unique molecular characteristics of aged antibodies such as their lower affinity, lower specificity, and increased cross-reactivity.

A special case of self-reactivity is idiotype interaction among different antibody molecules.²⁹ According to this concept, the unique antigen-combining site of each antibody molecule, called idiotype, is itself viewed as an internal antigen to which other antibodies can be made. Subsequent to antigen administration, the organism produces anti-antigen antibody. As the concentration of this first antibody (the idiotype of Ab1) increases, the combining site of this molecule is itself viewed as an antigen, and the organism may produce a second antibody (the anti-idiotype or Ab2) against the first. One of the predicted effector functions of this Ab2 is in part to down-regulate the production of Ab1.²⁹ Studies by Goidl and others have provided evidence that there is an age-related increase in the production of Ab2.²⁵ Increased production of Ab2 was associated with a change in the Ab1 repertoire; in particular, high affinity Ab1 was suppressed. It may be that increased Ab2 production in the aged exacerbates the potential for autoreactivity by down-regulating the high affinity B-cell clones, thereby allowing expansion of low-affinity, cross-reactive B cells.

Changes in antibody repertoire

Our studies on immunosenescence have shown that the aging process may be accompanied by a "molecular shift" in the antibody response. This term has been coined to describe the unexpected finding that the antibody molecules generated against the same antigen by mice of different ages are encoded by different germ line immunoglobulin genes. This finding was discovered in the anti-DNP antibody system³⁰ and in the anti-PC response.^{24,31}

When the antibody genes are studied in aged animals—in response to the PC antigen which is the immunodominant epitope of the well-studied strain of *Streptococcus pneumoniae*—the bulk of the antibody is specific for PC and protects animals against infection. In the normal adult mouse, the anti-PC antibody is uniformly encoded by a single immunoglobulin variable (V) gene family both for the heavy chain (V_HS107) and for the light chain (V_K22). In contrast, PC-specific antibody from aged mice turns out to be highly diverse; the heavy chains are now encoded by a number of different gene families (V_H7183, J558, X-24, S107, and possibly others), and none of the light chains is encoded by V_K22.²⁴ Such anti-PC antibodies are extensively cross-reactive and are never found in the young adult animal. For this antibody system, the amount of the antibody produced by the immune aged animals is as high, or at times even higher,³² than that obtained in the young mouse, but its molecular structure is different. In other studies of the anti-TNP

response, a similar difference in the V_H genes was seen between the responses of young and aged mice.^{27,33} The antibodies produced by the aged mice were immunologically promiscuous and recognized different antigens aside from TNP and were able to react against different epitopes. In contrast to the anti-PC response, the magnitude of the anti-TNP response in the aged is markedly diminished when compared with that obtained in the young animal. Therefore, the molecular shift seen in the antibody produced by the aged occurs independently of the amount of antibody produced.

Despite these dramatic shifts in antibody gene expression following immunization, our census of precursor B-cell population in unimmunized young and aged mice failed to reveal any substantial differences in heavy or light-chain V gene family use.³⁴ At the molecular level, these findings suggest that the **potential** antibody repertoire of young adult and aged mice is little different. If this is indeed the case, the molecular shifts seen in response **after** the immunization may be the consequence of altered regulatory pathways, presumably determined by T lymphocytes.³⁰

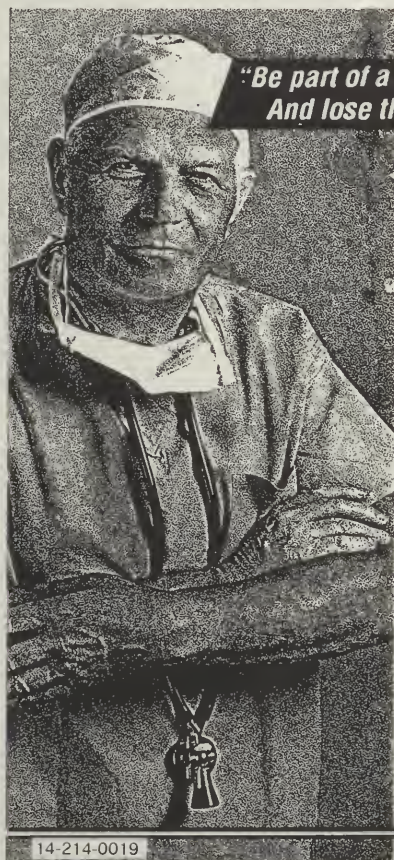
The key to understanding the immunosenescence of humoral immunity may be found in the observation that aged animals and humans produce antibodies that bind to antigens with much less affinity than the antibodies produced by the young.³² We have recently shown that the low affinity PC-specific antibodies from aged mice were unable to protect animals, whether young or old, against challenge with pneumococcus. In contrast, antibody from young immune donors fully protected both young and aged recipients (Nicoletti C, Cerny J. Manuscript submitted for publication). It would not be surprising that use of different V genes could influence antibody affinity. Shifts in gene usage could result from changes in the mechanism of DNA recombination or from immune network regulation. Alternatively, or in addition, interference with the process of antibody affinity maturation would also result in lower antibody affinities.

In conclusion, it appears that as a consequence of aging, the animal experiences a gene shift resulting in the production of antibodies that are structurally different and biologically ineffective. We believe that our studies of mice have potentially important medical implications. It is reasonable to speculate that human antibody responses to certain pathogens undergo a similar molecular shift, such that certain aged individuals would be producing apparently high levels of antibodies of the "wrong kind." In this case, the appropriate immunization strategy for the elderly would be a passive administration of the protective antibody from young donors rather than an attempt to boost the individual's own response with a more potent vaccine, because the shifted immune system can no longer make the right kind of antibody.

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A GREAT WAY TO SERVE

An overview of follicular development in the ovary: From embryo to the fertilized ovum *in vitro*

Larry D. Anderson, Ph.D. and Anne N. Hirshfield, Ph.D.

We summarize the current knowledge regarding the many events that take place during the transformation of the earliest primordial follicle into a preovulatory follicle, along with brief comments regarding the clinical extension of this elaborate process to the field of assisted reproductive technology.

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In normal women, every twenty-eight days, a single ovarian follicle is selected from many other growing follicles to complete its final maturation in preparation for ovulation. The preovulatory follicle is a highly specialized structure visible to the naked eye as a large bulge on the surface of the ovary. This intricate tiny organ, containing thousands of highly differentiated cells, arose from a mere handful of cells which make up the simple primordial follicle, a structure so small that it can only be seen at high magnifications with the light microscope. The ovarian follicle not only protects and nurtures the ovum, but also coordinates processes outside of the ovary that are required for successful fertilization and implantation. The complex developmental process that produces and selects a mature follicle for ovulation is folliculogenesis.

Many of the events that take place during the transformation of the earliest primordial follicle into a preovulatory follicle are beginning to be understood. Although many questions remain, modern technology is generating new information at a rapid rate. In this paper, we summarize the current knowledge of this elaborate process, along with brief comments regarding its clinical extension to the field of assisted reproductive technology.

Early events in folliculogenesis

During the embryonic period, precursor cell populations are established that later will be assembled into ovarian follicles. In the mouse, the primordial germ cells first appear outside the embryo, then migrate into the genital ridge where they colonize the undifferentiated gonad that develops from a mass of mesoderm on the dorsal body wall. The somatic

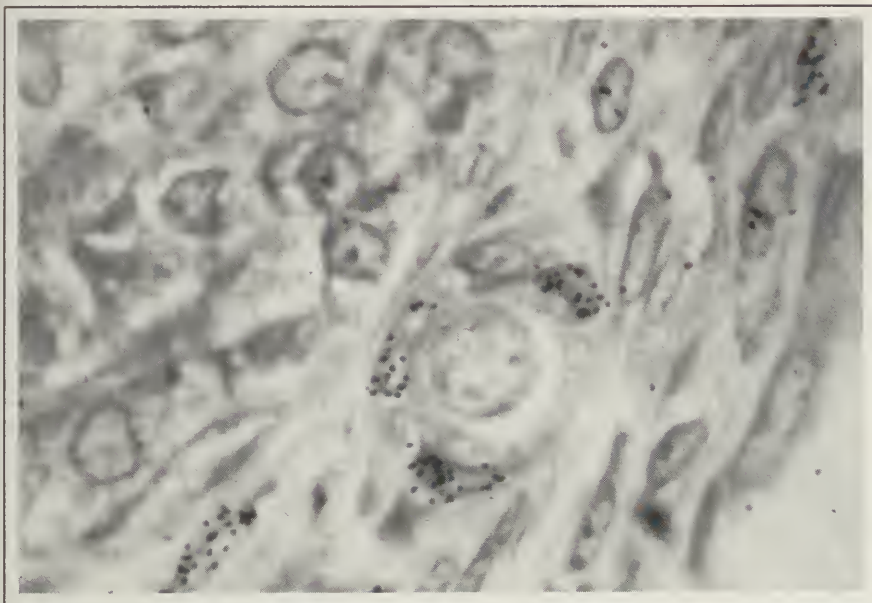


Figure 1. A follicle in the earliest stages of growth. This follicle of a twenty-three-day-old rat has six granulosa cells visible in its cross section. Three of the cells have incorporated ^3H TdR during a ninety-six-hour continuous infusion period. The granulosa cells are still flattened and crescent shaped, and the oocyte is still quite small—morphological characteristics shared with quiescent primordial follicles. Focus is on silver grains; original magnification: $\times 680$.

components that will later form the follicle (granulosa, theca, endothelial cells, and supporting connective tissue) are derived from this genital ridge mesenchyme.

After the germ cells invade the sexually-indifferent gonad, both they and the somatic cells undergo extensive hyperplasia. While the germ cells continue undergoing mitosis, the somatic cells of the gonad also rapidly proliferate.

In the female embryo, the formation of a definitive ovary involves two important events: transformation of the mitotically active germ cells (oogonia) into quiescent oocytes that begin to undergo meiosis, and organization of the somatic cells into discrete follicles. The meiotic process does not reach completion, leaving the oocyte in the arrested diplotene stage of the first meiotic division.¹

A dramatic event in this process is the death of vast numbers of oogonia occurring coincident with their entry into meiosis. This massive attrition causes the precipitous decline in germ cell numbers during early life. Once the germ cells cease to proliferate, no new oocytes are formed. The oocytes formed before birth thus constitute a finite and nonreplenishable population that must last for the individual's entire reproductive lifespan. It is from this pool of oocytes that all future developing follicles originate.

During the embryonic period, the

somatic cells of the gonad enclose individual oocytes to form primordial follicles. Each primordial follicle consists of a single small oocyte surrounded by a few flattened somatic cells. The process of follicle formation is not completely understood. Each fully-formed primordial follicle is enveloped in a complete basement membrane; this suggests that the formation of discrete follicles probably involves the synthesis of new basement membrane to seal off each "package" of pre-granulosa cells and its associated oocyte from its neighbor.

As the primordial follicles take shape, they enter a period of quiescence. During this period, the oocytes of quiescent primordial follicles remain arrested in the first meiotic prophase. Meiosis will not resume until just before ovulation.

Some follicles will leave this quiescent state and begin to grow as soon as they are formed, although most spend months to decades in the dormant state. The first sign of growth is the resumption of cell

proliferation by the squamous granulosa cells (**Figure 1**). In later stages of growth, the cytoplasmic and nuclear volumes of the oocyte increase dramatically,² and the granulosa cells proliferate rapidly. In rats, a typical primordial follicle in cross section contains approximately four granulosa cells. A full grown preovulatory follicle contains about 2,000–2,500 granulosa cells in cross section (**Figure 2**); thus, the granulosa cells that make up a preovulatory follicle are about ten genera-

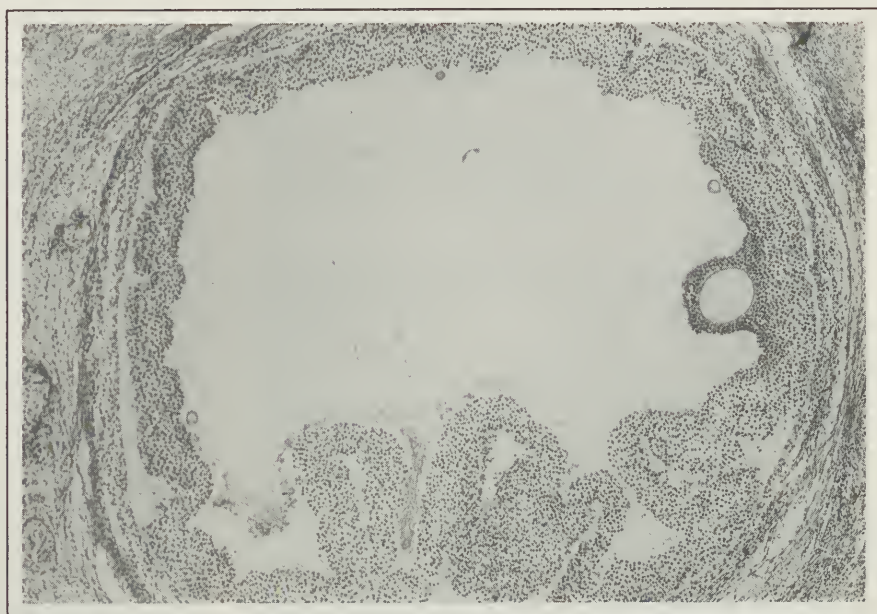


Figure 2. A preovulatory follicle of a rhesus monkey. The highly convoluted appearance of the granulosa layer is characteristic of ripe follicles of primates; original magnification: $\times 40$.

tions removed from the four granulosa cells in the primordial follicle from which they arose.³

During growth, the follicle acquires several distinctive morphological features. These include the formation of a capillary network and the appearance of distinctive layers of theca interna (steroidogenic cells) and theca externa (connective tissue cells) peripheral to the basement membrane of the follicle; a fluid-filled antral cavity; and a thick acellular zona pellucida surrounding the oocyte.

The appearance of the antrum heralds the final phase of folliculogenesis when cell proliferation ceases and mature functional features appear. Shortly after the large antral cavity is formed, some granulosa cells that border the basement membrane ("mural" granulosa cells) withdraw from the cell cycle. By this stage, the granulosa layer is markedly heterogeneous both in form and function.⁴ The theca layer of large follicles has also undergone marked morphological differentiation. Theca interna cells are located just outside the follicular basement membrane. This inner thecal layer is heavily laced with vascular channels. The outermost theca externa layer consists largely of cells that resemble fibroblasts (smooth muscle cells). The granulosa and theca cells of the fully mature follicle are highly differentiated with many tissue-specific, functional features including luteinizing hormone (LH) receptors,^{5,6} follicle-stimulating hormone (FSH) receptors,⁷ and the steroidogenic enzymes necessary to synthesize progesterone, androgens, and estradiol.

Regulation of follicular maturation

The acquisition of these structural and functional characteristics are orchestrated by numerous hormonal signals that originate from both outside and inside the ovary.

Extraovarian regulation. The gonadotropins (FSH and LH) of the pituitary gland are thought to be the primary extraovarian stimuli responsible for the final maturation of the follicle and ovulation. The thecal cells of the follicle have receptors only for LH, not FSH, while the granulosa cells of small antral follicles have few LH receptors and high numbers of FSH receptors.⁸ Concomitant with increasing follicular size, FSH gradually induces the appearance of greater numbers of LH receptors to reach their highest amount in synchrony with the ovulatory surge of LH.⁸

The maturing follicle does not respond passively to these gonadotropic stimuli, but actively participates through the secretion of steroid hormones and various proteins that exert feedback effects on the hypothalamic-pituitary axis. The principal steroids produced by the follicle are androgens and estrogens via a dual compartment system that is controlled by FSH and LH. The thecal cells contain all of the required enzymes to synthesize the various reproductive steroids, with the predominant hormone secreted being androstenedione (a very weak androgenic steroid). During the growth phase of follicles, LH primarily acts to maintain an adequate production of androgen from the theca. In contrast, the granulosa cells are not able to produce androgens due to a deficiency in

the enzyme, 17 α -hydroxylase, C_{17,20} lyase. In response to FSH and other factors, granulosa cells gradually acquire a very active aromatase (greater than the thecal cells).⁹ The granulosa cells are thus entirely dependent on the theca compartment as their source of androgens to produce the increased serum concentrations of estrogen required to trigger the LH surge and prepare the reproductive tract.

Reproductively active peptides are synthesized and secreted by the granulosa cells of the developing follicle which regulate the release of FSH from the pituitary gland.^{10,11} These peptides include substances with the suggestive names of inhibin, activin, and follistatin.¹¹ In the late 1970s, Channing and coworkers discovered an inhibitory activity in pig follicular fluid that suppressed FSH release.¹² This inhibitory material, termed inhibin, has now been isolated from the follicular fluid of several species, its gene sequenced, the primary structure determined, and recombinant forms made available for physiological studies.¹¹ Inhibin is a 32,000 dalton protein (although higher molecular forms also exist) that is composed of α and β -subunits joined by disulfide bonds. Activin is a 24,000 dalton protein, composed of the $\beta\beta$ dimer of the subunits of inhibin, which has the opposite effect of inhibin (i.e., stimulation of FSH secretion). The stimulatory activity of activin is directly regulated by a single chain 35,000 dalton protein—follistatin—that serves as a binding protein for activin.¹¹

Intraovarian regulation. Within the last decade, a number of hormones have been identified within the ovary that act mainly through their synergistic or antagonistic effects on gonadotropic stimulation.¹³ Generally, these hormones and factors are considered to exert their actions primarily by an autocrine or paracrine mechanism (i.e., local modulation of the same cell from which the substance was secreted or by its effect on neighboring cells within the tissue).

The concept of intraovarian control of the follicular cells was pioneered by the late Cornelia P. (Nina) Channing in the Department of Physiology at the University of Maryland at Baltimore. This notion originated with her observations that some factor(s) in follicular fluid could maintain the oocyte, *in vitro*, in its meiotically arrested state (a fully developed oocyte will normally undergo meiosis spontaneously when isolated from the follicle prior to the LH surge).¹⁴ This oocyte maturation inhibitor (OMI) is a small peptide of approximately 2,000 daltons that is secreted into the follicular fluid from granulosa cells of small developing follicles.^{15,16} The secretion of OMI is hormonally regulated¹⁵ (Figure 3) and acts in conjunction with cAMP (cyclic adenosine monophosphate) to maintain the intracellular communication between the granulosa cells, cumulus/corona, and the oocyte via gap junctions, thereby permitting continued transfer of the inhibitory effects of cAMP to the oocyte.¹³

It is well documented that estrogen has a crucial role in folliculogenesis by regulating the secretion of the gonadotropins from the pituitary gland. However, the role of estrogen as a local ovarian regulator of the follicle has been

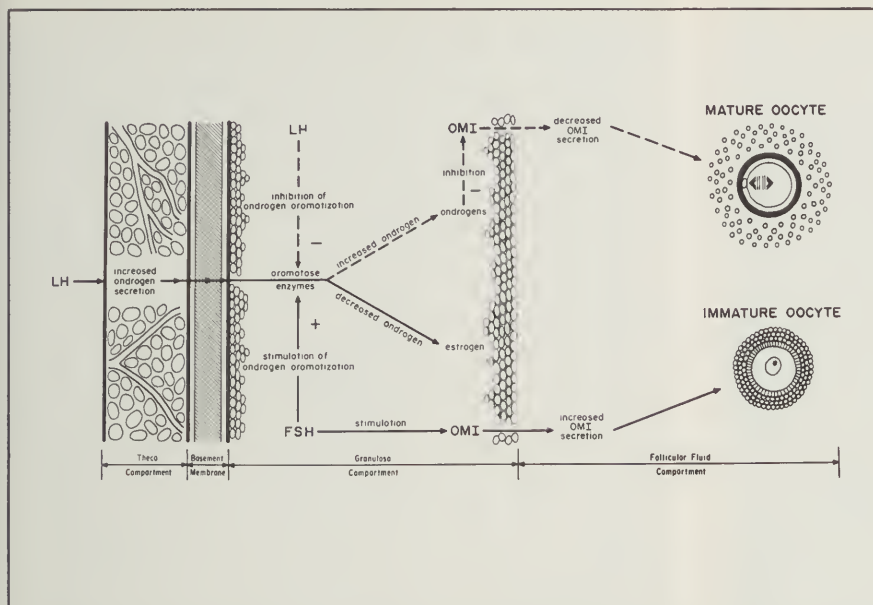


Figure 3. An hypothesis of the control of oocyte maturation inhibitor (OMI) secretion by hormones within the porcine follicle. Prior to ovulation, luteinizing hormone interacts with the theca interna cells of the ovarian follicle (left) to maintain increased androgen biosynthesis. In addition to aromatization by the theca cells, the androgen transveres the basement membrane to interact with the granulosa cells (center). Androgen is converted in granulosa cells to other androgens, testosterone, and C_{18} neutral steroids, and to estrogen by the aromatase complex that is stimulated by FSH. Furthermore, FSH directly stimulates the secretion of OMI from granulosa cells and maintains the oocyte in an immature state (lower right). At any time during follicular development, the loss of FSH responsiveness or receptors, the aromatase enzymes, and/or an increase in androgen would result in atresia and the attenuation of OMI secretion; thereby, the oocyte is allowed to undergo maturation (upper right) and degeneration in the unruptured follicle. An analogous situation may occur during the LH surge (i.e., LH stimulates theca cell androgen secretion while inhibiting its conversion to estrogen in granulosa cells). As a result, the increased androgen, testosterone, and C_{18} neutral steroids would also attenuate OMI secretion allowing the oocyte to resume meiosis. (Reprinted with permission from Anderson LD, Stone SL, Channing CP. Hormonal control of oocyte maturation inhibitor secretion by cultured porcine granulosa cells. *Gamete Research* 1985; 12:119–30.)

controversial, particularly with the recent evidence demonstrating a lack of estrogen receptors within the follicular cells of the primate. Attention is being shifted toward androgens that may serve as autocrine or paracrine regulators of follicular functions, since various clinical abnormalities result from an imbalance of androgen production and metabolism (e.g., polycystic ovarian disease and hirsutism). Furthermore, androgen receptors recently have been shown to be localized in the nuclei of the granulosa and theca cells throughout all stages of follicular development in the primate.¹⁷ Until recently, far less attention has focused on androgen metabolites of androstenedione. Specifically, these include testosterone and the novel C_{18} neutral steroids—in particular, the highly androgenic and anabolic steroid, 19-nortestosterone (commonly referred to as nandrolone). While testosterone is effective in exerting classic androgen effects, 19-nortestosterone is one of the most potent due to its greater binding affinity for the androgen receptor (two to three-fold greater than testosterone). In fact, this steroid, or its synthetic analogs, is identical to that reported to be abused by athletes for increased performance and hypertrophy of skeletal muscle mass. The presence of naturally occurring C_{18} neutral steroids

in the follicular fluid of the gilt, mare, and human has been recognized for several years, but remained enigmatic partially due to the inability to identify the enzymatic mechanism by which they are produced in the follicle. Recently, we have identified 19-oic-androstenedione (19-oic-A), the carboxylic acid of androstenedione, as the missing link in the enzymatic pathway for the formation of C_{18} neutral steroids by the granulosa cells.¹⁸ The amount of 19-oic-A produced by granulosa cells is equivalent to, or greater than, the amount of estradiol produced. Moreover, the conversion of 19-oic-A to C_{18} neutral steroids is increased coincidentally with the transformation of the granulosa cells to luteal cells.¹⁸ During this transformation, the granulosa cells undergo dramatic changes that are indicative of androgenic-anabolic regulation—i.e., loss in mitotic activity, massive hypertrophy (five-fold within two to three days), and the induction of enzymes required to secrete progesterone.

Within the last several years, there has been a plethora of reports describing the effects of locally produced growth factors on various granulosa cell functions, *in vitro*. This active area of research has focused mainly on the interplay between the potent granulosa mitogens, epidermal growth factor (EGF), and transforming growth factor alpha ($TGF-\alpha$), and the ef-

fects of insulin-like growth factor I (IGF-I) to promote differentiation.

Assisted reproductive technology

The advances in knowledge of reproductive physiology spanning several decades led to the first human ova to be fertilized *in vitro* and the resulting embryo successfully reaching term and being delivered in Great Britain.¹⁹ Mixed emotions and controversies were stimulated by this accomplishment fourteen years ago, not only in the scientific community, but among politicians, religious leaders, and people around the world. General interest in reproductive physiology soared, similar to that following the introduction of the birth control pill, and infertile couples now clung to the hope of conceiving their own genetic offspring. This test tube baby procedure, referred to as assisted reproductive technology or ART, is now rapidly becoming commonplace in most urban centers. The 180 ART clinics registered in the United States reported a total of 3,951 live deliveries during 1990.²⁰ The overall procedure is now fairly standardized, with subtle variations depending on the expertise and facilities of the individual clinic.

Couples are first evaluated to diagnose their particular infertility problem(s). These may range from unexplained infertility of both partners to severe problems of the female (e.g., endometriosis resulting in nonpatent oviducts with irregular menstrual cycles or polycystic ovarian disease) or the male (e.g., low sperm count with morphological abnormalities, or an inability to ejaculate normally as with spinal cord lesions, retrograde ejaculation, or reversed vasectomy). The results of these evaluations also determine the specific ART procedure to be performed for each couple.

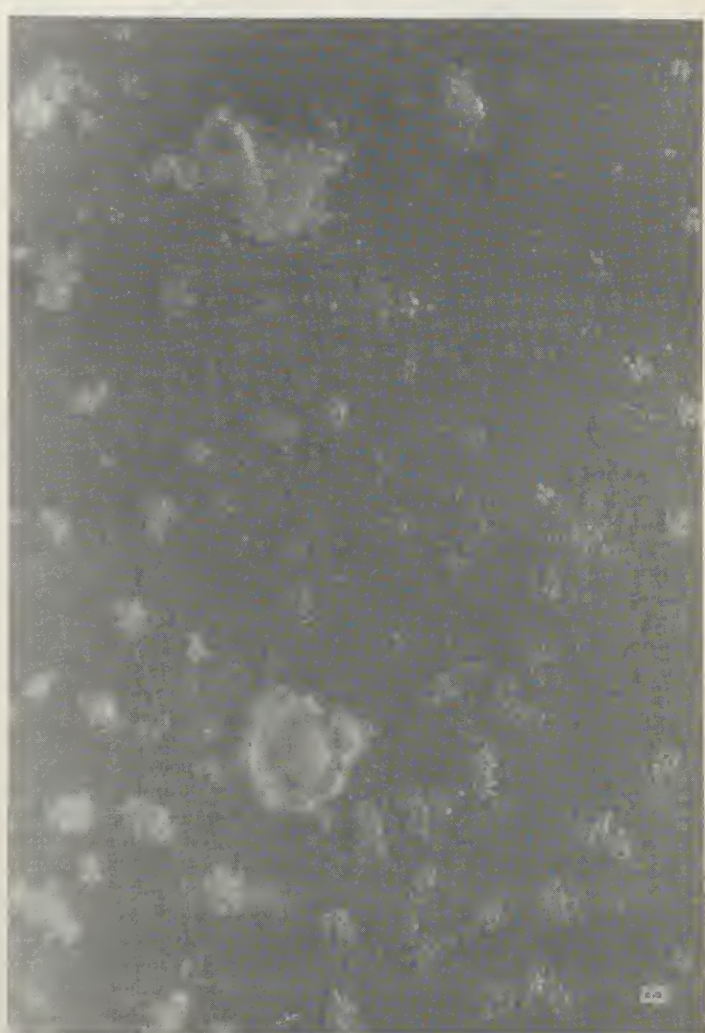
Currently, most clinics begin these procedures with the administration of a drug to down-regulate the hypothalamic-pituitary system (LHRH agonist).²⁰ This process decreases serum concentrations of the gonadotropins, and developing ovarian follicles degenerate, thereby providing a set of new follicles at earlier stages of development. This permits more precise control of the maturation of these new follicles by administration of exogenous gonadotropins in the absence of influences by the hypothalamic-pituitary axis. The progress of maturation and the numbers of growing follicles (usually four to ten stimulated per ovary) are monitored by daily observations using ultrasound and serum estradiol determinations. When the follicles attain preovulatory size (18-21 mm) and estradiol concentrations continue to rise linearly, the ovulatory response is initiated by exogenous administration of human chorionic gonadotropin (hCG).

The eggs are retrieved from the follicles thirty-three to thirty-four hours after hCG treatment by transvaginal aspiration guided by ultrasound. This time period is sufficient to allow most oocytes to mature to the metaphase II stage while still remaining within the follicle prior to ovulation. Using a microscope, each follicular aspirate is examined for the presence of an oocyte-cumulus complex (Figure 4A). Once located, the oocyte is evaluated morphologically and transferred to a petri dish (not a test tube) containing culture media and heat-inactivated serum. A semen sample is provided by the male partner and processed using a "swim up" procedure, whereby the most active, motile sperm will be obtained for insemination. If the female's oviducts are patent, an ART procedure called GIFT (gamete intrafallopian transfer) can be performed at this time. By this approach, oocyte-cumulus complexes surrounded by sperm are placed directly into the oviducts by laparoscopy. This procedure best simulates the normal sequence of events and permits fertilization to occur within the oviducts. Not surprisingly, GIFT has the highest success rate, with 22 percent of the 3,750 patients undergoing ova retrieval in 1990 having a live delivery.²⁰ An alternative procedure, ZIFT (zygote intrafallopian transfer), permits the selection of *in vitro* fertilized zygotes to be transferred to oviducts the day following ova retrieval (Figure 4B and C). The success rate for this procedure in 1990 was 16 percent based on 1,370 patient ova retrievals.²⁰ Extra zygotes can be cryopreserved at this time for future transfer or for donation to couples without female gametes. Most patients have more serious infertility problems, however, requiring an additional

one to two days of incubation in culture so that preembryos in the early cleavage stages can be selected for transfer to the uterus (Figure 4D). This IVF-UT (*in vitro* fertilization-uterine transfer) procedure entails the transcervical transfer of several 2-6 cell (day 2) or 8-16 cell (day 3) preembryos to the fundus of the uterus (4-5 preembryos provides optimal success). In 1990, the rate of success for IVF-UT was 14 percent based on 16,405 patient ova retrievals in the United States.²⁰

As additional treatment centers expand and clinical procedures are modified to incorporate discoveries from basic investigations, the success rate should substantially improve. New technologies should also provide solutions to infertility problems for a broader spectrum of human patients, along with domestic animals and endangered wild species. Improvements in methods of micromanipulation allow microinjection of a single sperm or surgical removal of portions of the zona pellucida to aid fertilization and embryo implantation.²¹ With the advent of the polymerase chain reaction technique and the identification of genomic mutations and lesions, it is now possible to remove a single blastomere, amplify the deoxyribonucleic acid (DNA) signal of the removed cell, and genetically screen embryos before transfer to the female recipient.²² As cryopreservation techniques are improved, it will become possible to store oocytes in a manner similar to storage of male gametes in sperm banks.²³ This storage process will permit young couples to determine the appropriate time to conceive years later or to donate unfertilized oocytes to females without ovaries. These advances will undoubtedly spur further debates on personal liabilities and

Figure 4. Human oocyte-cumulus complex, fertilized ovum, and 4-cell preembryo at various stages of the ART procedure. A. Oocyte-cumulus complex on the morning of follicle aspiration (retrieval), approximately thirty-four hours after the injection of hCG. Oocyte (egg) at the end of the arrowhead. Magnification: x40. **Inset:** Forty-three hours after hCG, the oocyte (central sphere) is surrounded by the corona cells (ring of darker cells) embedded within the cumulus mass (lighter colored cells). Typical appearance at the time of addition of sperm (insemination). While the oocyte remained in incubation (34-43h), sperm are isolated by a "swim up" procedure, then a diluted preparation of motile sperm is introduced by pipet to achieve 75,000 to 200,000 sperm per oocyte. Oocytes most ready for fertilization will have a polar body at this time. Fertilization can occur as quickly as three hours after the introduction of the sperm to the culture dish. Magnification: x140. B. Oocyte with surrounding coronal cells still attached at approximately sixteen hours after insemination (fifty-nine hours after hCG injection). The isolated clumps of cells are the remnants of the cumulus complex dispersed by overnight sperm digestion of the extracellular matrix. To evaluate the oocyte for possible fertilization, the remaining corona cells must be removed by passing the oocyte-coronal complex through a series of finely drawn pipets of decreasing diameter (final pipet is 175-185 μ m i.d.). Magnification: x60. C. High quality fertilized ovum (zygote) approximately sixteen hours after insemination with the bulk of coronal cells removed. The zygote is surrounded by its outer acellular membrane (zona pellucida). The polar bodies, two at this stage, are not visible. The male (larger) and female (smaller) pronuclei are visible in the center of the zygote. In this zygote, the pronuclei have become closely apposed and will shortly fuse. Cell division (cleavage) will then follow. The zygote will remain in the pronuclear one-cell stage for approximately twenty-four hours after fertilization. Magnification: x650. D. High quality preembryo at the four-cell stage approximately eighty-three hours after hCG injection (forty hours after insemination). Several sperm and a small clump of coronal cells are attached to the outer surface of the zona pellucida. Magnification: x525.



responsibilities, along with ethical and legal implications of these new technologies.²⁴

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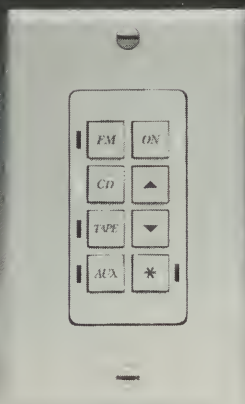
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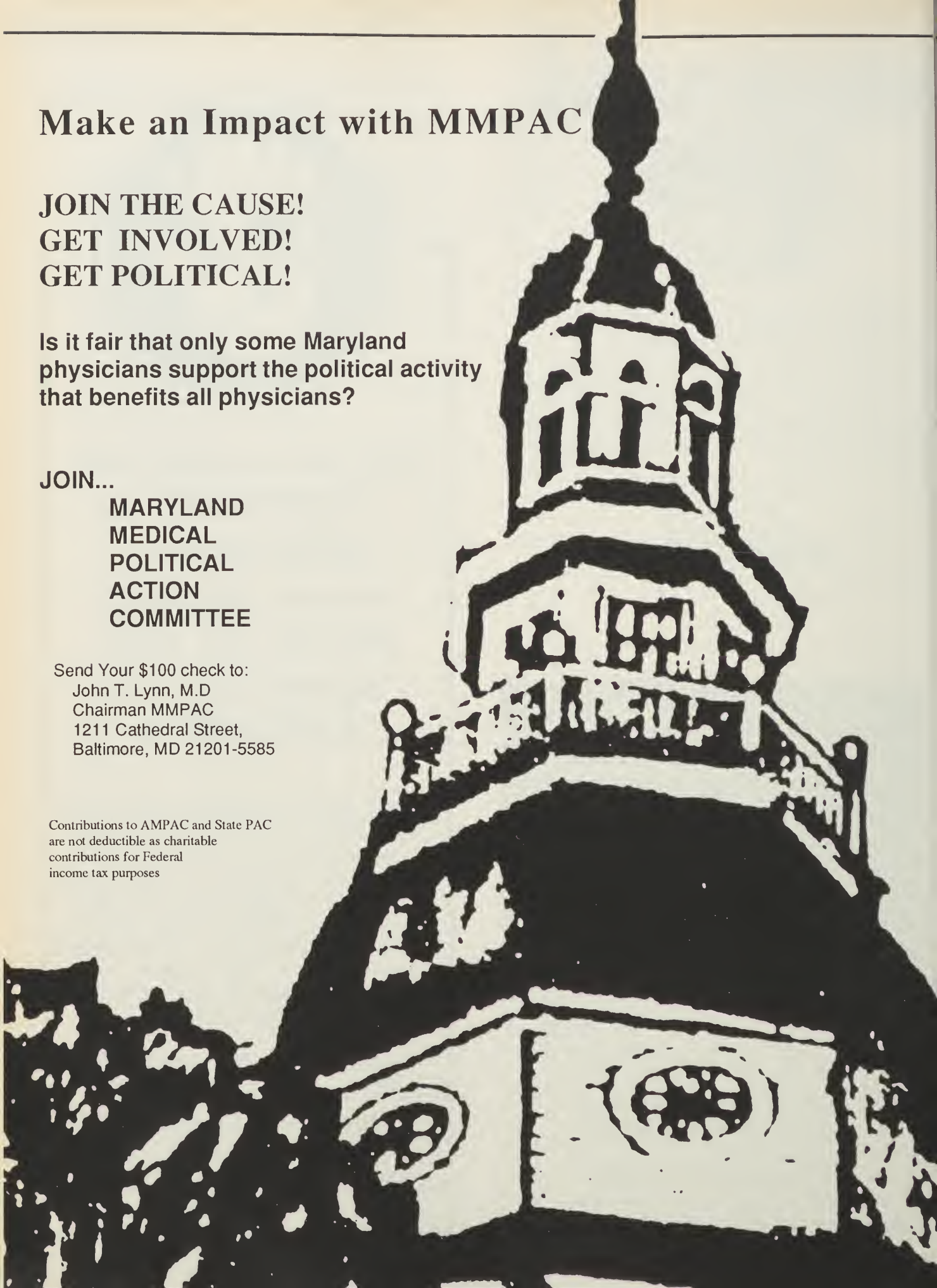
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Progress in understanding the nicotinic acetylcholine receptor function at central and peripheral nervous system synapses through toxin interactions

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The need to treat diseases affecting the nicotinic AChR is great, but therapeutic options are few. Through careful correlation of structure-activity relationships of AnTX analogs, we may ultimately be led to the development of diagnostic and therapeutic drugs with specific nicotinic agonist or antagonist activities in the central nervous system that would be of major importance in the treatment of Alzheimer's disease.

A healthy human brain easily engages in high order functions of cognition and memory. While the mechanism of these functions is not entirely understood, their significance is profoundly highlighted by their malfunction in neuronal deficiencies such as senile dementia, stroke, and mental retardation. For example, patients with Alzheimer's disease are progressively incapacitated by deterioration in memory, personality, and intellect. Although pathological examination of postmortem brains has repeatedly shown the presence of neurofibrillary tangles and amyloid plaques, a deficit of cholinergic function occurs relatively early during Alzheimer's disease.¹ Degeneration of the magnocellular cholinergic basal forebrain system in the nucleus basalis of Meynert, medial septum, and diagonal band of Broca probably contributes to the reduction of cholinergic markers in the cortex,² including loss of nicotinic AChR (acetylcholine receptor).³ This observation, along with pharmacological studies (e.g., the amnesic potency of scopolamine, which is both a muscarinic and nicotinic antagonist) in man and animals, has led to the hypothesis that cholinergic deficits are a primary factor in the disease. Attempts to stimulate cholinergic function by treatment with cholinesterase inhibitors such as physostigmine and tetrahydroaminoacridine (both have many other effects that do not depend upon cholinesterase activity) have had limited success in the ability to improve cognitive and mnemonic function in patients.⁴

Other neurotransmitter systems also contribute to brain deficits, e.g., norepinephrine, serotonin, GABA (gamma-aminobutyric acid), and glutamate. In particular, glutamatergic synapses, which are key to the development of long-term potentiation in the limbic system and neocortex, and pyramidal neurons, which carry excitatory transmitters, are reduced in later stages of Alzheimer's disease. The recent discovery that presynaptic nicotinic AChR releases several types of transmitters, suggests a mechanism by which the cholinergic system may regulate the release of many transmitters.⁵ Detailed information on receptor function is essential prior to proposing therapeutic regimens for mnemonic disor-

ders. Molecular biologists have recently provided evidence for a heterogeneous population of neuronal nicotinic AChRs. However, the precise functions of these neuronal AChRs are virtually unknown, and, indeed, they have only recently been observed with the modern patch clamp recording technique (single-channel and whole-cell current recordings).⁶⁻⁸

Our laboratory now has the occasion to investigate the neuronal nicotinic receptor with selective probes; particularly interesting are some anatoxin (AnTX) derivatives that we have shown to be selective neuronal agonists.

The peripheral type of nicotinic AChR, found in vertebrate muscle and *Torpedo* electroplaque, is the best characterized neurotransmitter receptor and is a prototype for the family of ligand-gated channels [see excellent reviews⁹⁻¹²]. Receptor activation takes place by the binding of agonist to each of two α -subunits of a pentameric complex, which then transiently forms a semi-selective cation channel through the complex, involving participation of all subunits.

The measurement of currents through the AChR ion channel enables electrophysiologists to assess the activity of the receptor. Traditional methods such as intracellular recording and voltage clamping, which measure the currents in large populations of channels, have been supplemented by the cell-attached patch clamping method. By forming a high resistance ($G\Omega$) seal between a membrane and a patch electrode, the electrical noise is greatly reduced and the current through individual channels is observed. (For a general overview of the significance of the patch clamp technique to modern neurobiology, see the recent report by Neher and Sakmann.¹³)

The single currents through AChR are (predominantly) step-like currents with uniform current amplitude and variable durations. Stochastic analysis of the durations of the open and closed states yields information about the kinetics of transitions between various receptor states: open, closed, blocked, and desensitized.¹⁴ Thus, the patch clamp method can describe the mechanism of pharmacological selectivity of drug analogs. At the AChR, which has several ligand-binding sites, it is particularly important to identify the mechanism of drug action.

(+)AnTX, a natural product in the algae *Anabaena flos-aquae*, was selected as the focal compound for studies of the pharmacology of the AChR in the peripheral nervous system. Our early findings indicated that AnTX would serve well in further biophysical and pharmacological studies.¹⁵ AnTX's ideal characteristics are (1) high agonist potency for the peripheral AChR;¹⁶ (2) high stereospecificity not found with other ligands;¹⁷ (3) high selectivity in brain tissue for nicotinic

over muscarinic receptors;¹⁸ and (4) insensitivity to cholinesterase.¹⁷ AnTX and twenty-two analogs were synthesized in pure form.¹⁹⁻²¹ The frog muscle contracture assay was used to assess the agonist potency of the ligands (**Figure 1**). Although no analogs were more potent than the parent compound AnTX, the systematic structural modifications elucidated several aspects of the structure-activity relation-

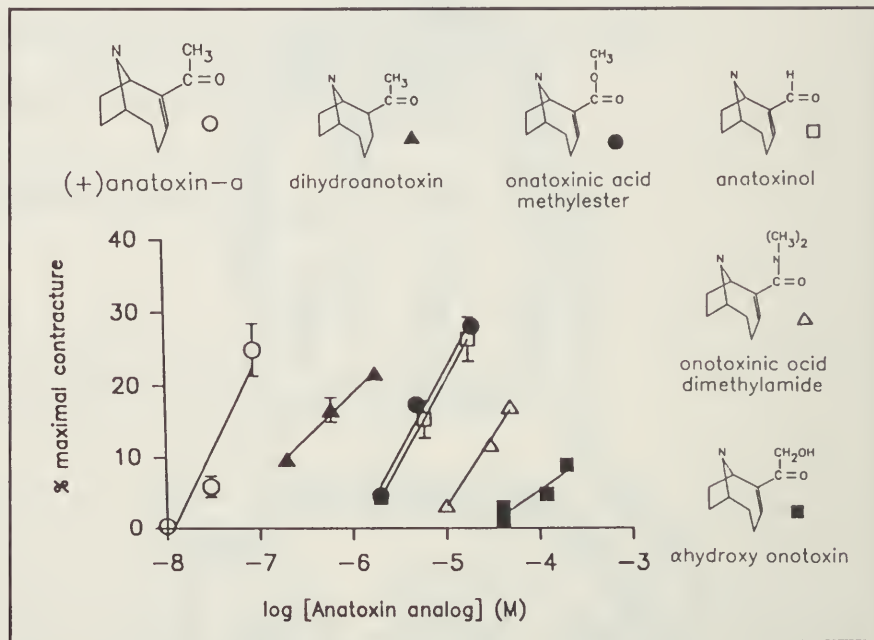


Figure 1. The side-chain structure-activity relationship for AnTX analogs in the keto side chain series. The potency was measured in frog *Rana pipiens* rectus abdominis muscle as the ED₂₀, the concentration that would produce 20 percent of the maximal contracture elicited by K⁺ depolarization. The side chain structure of each analog is shown along with the potency data.

ship at the peripheral AChR.

Considering that these same chemical moieties might modify specific functional properties of the receptor through various mechanisms, studies of ligand binding were undertaken. Radioligand competition binding assays using *Torpedo* electroplaque and frog muscle determined inhibition of [¹²⁵I]α-bungarotoxin binding (IC₅₀ αBGT) to the agonist site. The stimulation of [³H]-perhydrohistrionicotoxin binding (EC₅₀ [³H]H₁₂-HTX) to the ion channel binding site was a biochemical index of ion channel activation.²² The correlation between affinity and potency across all compounds with significant agonist activity was excellent (**Figure 2**).²³ These analogs also demonstrated antagonist activity by their inhibition of muscle twitch evoked by nerve stimulation and by competition with [³H]H₁₂-HTX for the ion channel site. The kinetics of the molecular processes involved have been examined further using the patch clamp, single-channel-current recording technique, where appropriate, to observe changes between the multiple states of the AChR. Several compounds had interesting and selective properties.

Surprisingly, methylation of the amine in eleven analogs of AnTX resulted in very weak agonists,²³ in contrast to

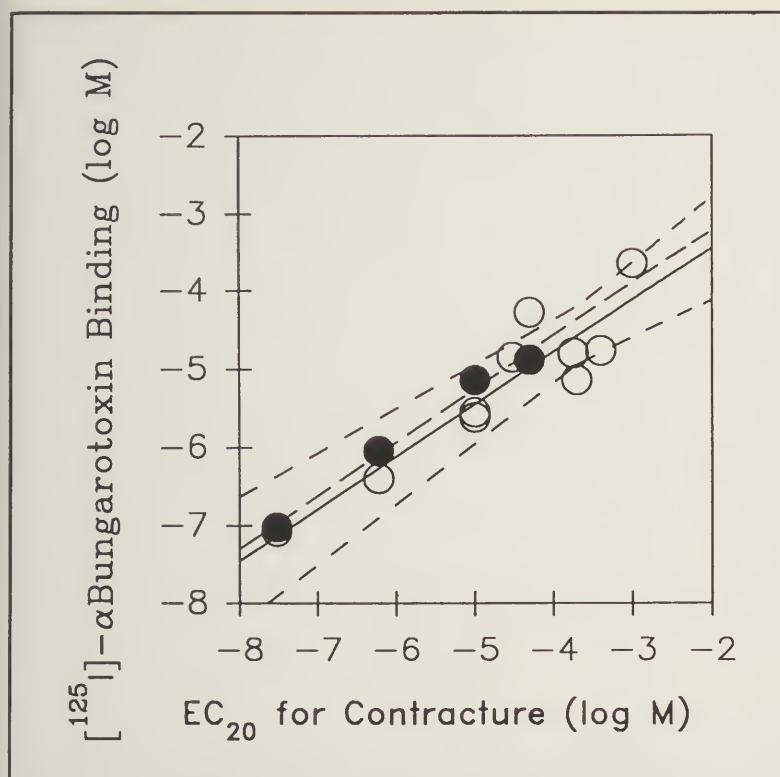


Figure 2. Correlation of [125 I] α BGT binding to *Torpedo* electroplaque (O, Ki) and frog muscle (●, IC₅₀) with potency measured as EC₂₀ for contracture of frog muscle.

increased potency achieved by methylation of ferruginine (AnTX's close structural relative) and other agonists.²⁴ The simplest of these analogs, N-methylAnTX and N,N-dimethylAnTX, showed that the decrease in potency was specific to methylation of the amine. These methylated analogs are weak agonists due to low affinity for the agonist site and low stimulation of ion channel openings.^{25,26} Molecular dynamic calculations of the structures suggest that added methyl groups force a change, with respect to the stable skeleton of AnTX, from a boat to a chair conformation.²⁷ At the high (μ M) concentrations necessary for these analogs to produce an agonist effect, rapidly reversible ion channel blocking properties and synergistic desensitizing actions became particularly noticeable. Although the distribution *in vivo* of the quaternary analog would be restricted to peripheral tissues, the additional antagonist properties preclude the use of N,N-dimethylAnTX as a selective peripheral nicotinic agonist.

The nonmethylated analogs of AnTX had moderate agonist potencies that could be compared with the chemical structures (**Figure 1**). Several chemical hypotheses were tested. Beers and Reich had suggested that cation and hydrogen-bonding components were essential to agonists.²⁸ For the AnTX analogs, the H-bonding strength sequence (aldehyde > ketone (AnTX) > ester > amide) compared poorly with the observed affinity and potency sequence (ketone (AnTX) > aldehyde \approx ester > amide). Furthermore, the primary and tertiary alcohol analogs were much less potent than the secondary alcohol analogs, in contrast to predictions based on the

H-bonding strength that the tertiary alcohol would be most potent and the primary alcohol would be the least potent. Therefore, the ability of the alkyl side chain to form H-bonds seems to be less important than other steric features.²³ Not only the planarity of the proximal carbonyl moiety²⁹ but also the distal side-chain structure seem to be important elements of the molecular structure.²⁸

Except for AnTX and H₂-AnTX, many other analogs were equally or more potent as ion channel blockers than they were as agonists. For several analogs (AnTX, (-)AnTX, N-methylAnTX, N,N-dimethylAnTX, (S)-N-methylAnTXol), the kinetics of blockade were nearly identical^{25,26,30} and appeared to follow voltage- and concentration-dependent kinetics similar to those of many charged alkaloid ion channel blockers.³¹ We have also found that both (-) and (+)nicotine produced prominent, nonstereospecific blocking effects that were unclear prior to single channel analysis.³² For (R)-N-methylAnTXol, the blockade was stronger according to antagonism of [3 H]H₁₂-HTX binding, and the mechanism was unusual for the lack of voltage-dependence.³⁰ This compound likely binds with high affinity due to van der Waals forces. In addition, AnTX- α OH also had high affinity for the ion channel site. On the other hand, a few analogs, including an aldehyde analog, had almost no ability to inhibit [3 H]H₁₂-HTX binding.²³

An important consideration for neuromuscular agents is their antagonist action as depolarizing blockers. Whereas a low concentration of AnTX (e.g., 20 nM) in a patch pipet produces a steady low frequency of ion channel activation, approaching 1 μ M of AnTX results in clusters of high activity interspersed between long periods of inactivity due to desensitization. AnTX also produced ion channel blockade at high micromolar concentrations that also caused desensitization, thus requiring kinetic dissection of multiple types of closed events in single-channel recordings.²⁶ Receptor desensitization by AnTX analogs during single-channel recordings has been largely obscured from analysis by ion channel blockade beginning at lower concentrations than does desensitization. Some effects of desensitization were evident using combined agonists (e.g., N,N-dimethylAnTX produced much greater desensitization when combined with ACh than would be expected from the sum of the two ligands acting independently²⁵). This synergism probably arises through an action of N,N-dimethylAnTX at an allosteric site regulating desensitization. The studies thus far described on the peripheral nicotinic AChR demonstrated the ability and sensitivity of our molecular pharmacological methods and analyses to find subtle differences between chemical actions.

Beyond the potent antagonism of the neuromuscular transmission, AnTX toxicity in the rat clearly has components of central nervous system (CNS) activity such as tremor and convulsions. These may arise from both presynaptic and

postsynaptic actions. Iontophoresis of AnTX onto endplates increased the frequency of miniature endplate potentials.¹⁶ Nicotinic stimulation also evoked transmitter release in the CNS.³³ Up-regulation of the AChR population occurs during chronic treatment with AnTX³⁴ and other nicotinic agonists. Furthermore, behavioral responses of rats showed that AnTX produced a partial nicotine-like stimulus.

Considerable interest in the neuronal nicotinic AChR has been fostered by the expanding field of molecular biology. The heterogeneity of brain AChR is substantiated by several isoforms of the α -subunit³⁶⁻³⁹ and recordings from neuronal receptors with multiple conductances.^{6,7,40,41} Comparing the protein sequence of peripheral (muscle or *Torpedo*) and three neuronal α -subunits, there is a low degree of homology in the regions of the agonist binding site and the amphipathic, ion channel forming helix.³⁸ The differences in these regions support our notion that one can distinguish the receptor types electrophysiologically and develop selective agonists.

The neuronal AChRs differ from those at the neuromuscular synapse with respect to their functional properties and pharmacological profiles.^{6,42-44} At the muscle AChR, binding sites for agonists (ACh and (-)nicotine) are closely associated with overlying sites for α BGT. In lower vertebrate brains, α BGT produces functional antagonism, which suggests a close resemblance of the receptor to the muscle AChR.^{45,46} Homology between the nicotinic AChRs of the optic tectum and muscle in chicks supports this premise.⁴⁷ In mammalian brain, the [³H](-)nicotine high-affinity site coincides with that labeled by [³H]ACh^{48,49} and parallels the immunohistochemical AChR localization,⁵⁰ but [¹²⁵I] α BGT binds to an independent site.^{47,51,52}

Optically pure nicotine enantiomers were paramount for the characterization of several sites in the brain. Each brain AChR carries one high and several low affinity sites for both (-)nicotine and ACh.⁵³⁻⁵⁶ Whereas the agonist site on muscle AChR has only a five to eight-fold difference in the potency of nicotine enantiomers,³² the high-affinity (-)nicotine site in the brain displays eighty-fold greater affinity for the (-) enantiomer.⁵³ Similar stereoselectivity is found for (-)nicotine-induced transmitter release from brain synaptosomes.³³ The low-affinity site for nicotine exhibits little stereoselectivity and is also labeled by [¹²⁵I] α BGT. Despite blocking the receptor function, some antagonists such as mecamylamine fail to compete for the high affinity (-)nicotine site, suggesting an interaction with allosteric sites on the receptor involved in desensitization and channel blockade, as we have described in muscle.^{32,57} Presently known antagonists do not clearly discern the various low-affinity sites.⁵⁸

The high potency,¹⁶ stereoselectivity,¹⁷ and specificity for the nicotinic versus muscarinic receptor in the CNS¹⁸ and easy penetration into the brain are properties that make (+)AnTX a uniquely superior probe for assessing central AChRs. Our initial work with (+)AnTX at neuronal AChRs has been fruitful. AnTX is one of the most potent and specific probes for the AChR in mammalian brain. At the high affinity [³H](-)nicotine site in rat brain, AnTX has a K_i of 0.34 nM

and discloses marked (1,000-fold) stereoselectivity of this site.⁵⁹ Therefore, (+)AnTX is even superior to (-)nicotine in distinguishing (-)nicotine and α BGT sites in mammalian brain AChRs.^{53,59} Analogs of the (+) isomer of AnTX, differentiated on the side chain, at first appear to have generally similar affinity for the rat brain nicotinic AChR as for peripheral AChR, as determined by competition for the [³H](-)nicotine site.⁶⁰ However, the affinities of AnTX-methoxamide and AnTX-isoxazolidide were orders of magnitude greater in the brain than their affinities at either neuronal or peripheral α BGT sites.⁶⁰ Therefore, these selective central ligands may become useful compounds. Their use in the electrophysiological analysis of neuronal AChRs is preeminent. The structural correlations of these compounds hint at the possibility that longer side-chain analogs are more potent at the neuronal AChR than at the somatic AChR.

The central nicotinic AChR of cultured and acutely dissociated brain stem neurons, hippocampal pyramidal cells, and retinal ganglion cells responded to both AnTX and ACh at 0.1 to 5 μ M in patch clamp studies using the cell-attached or outside-out patch clamp recording configuration (**Figure 3**).^{6,61} As with AChRs on cultured myoballs³¹ and isolated, chronically denervated muscle fibers,⁶² and with glutamate receptors on cultured neurons,^{63,64} multiple conductance receptor states could be discerned in some patches. The distribution of conductances was similar to that observed in cultured myoballs excited by ACh³¹ or AnTX. The predominant population of AChRs found on cultured brain stem neurons had a conductance of 20 pS (10°C, Q_{10} =1.3-1.5).⁶ Using the outside-out patch clamp configuration, it was possible to record both inward and outward currents over a larger range of clamp potentials, and a slope conductance value of 40-45 pS (22°C) was obtained for the predominant population of single-channel currents.⁶¹ Even after considering the Q_{10} value, these currents appear to have larger conductance than the current previously mentioned. The conductance was the same for (+)AnTX-activated currents in hippocampal neurons and in retinal ganglion cells.

Much higher (μ M) concentrations of AnTX were necessary to stimulate the neural AChR than the muscle AChR (nM). Although muscle AChRs usually show some desensitization, represented by clustering of channel activity at high concentrations of agonists, this pattern was not observed in cultured neurons.⁶ Instead, randomly occurring single-channel events with occasional step-wise multiple activations due to simultaneous openings of two or more channels were recorded.

The kinetic properties of the neuronal receptors were qualitatively similar, despite the different conductances. In the early experiments, the 20 pS channels activated by ACh showed only a few interruptions during the open state of the channels, but the AnTX-induced channel openings contained many flickers. The later experiments revealed that the 40-45 pS currents in hippocampal neurons had a mean open time of about 2 msec at -80 mV, and mean flicker duration of approximately 1 msec; very similar results were obtained in retinal

ganglion cells. The open time of currents activated by AnTX in the CNS (both hippocampal cells and retinal ganglion cells) was markedly shortened by hyperpolarization from -80 to -120 mV due to the presence of many fast flickers within each burst at these potentials (Figure 3).⁶ At -80 mV, bursts might have 20–30 flickers and the number of openings per burst increased with hyperpolarization. These findings are preliminary and require further quantification. Yet, it is intriguing

low density on the soma, where the patch clamp recordings were necessarily done. There is considerable evidence that many AChR are present on presynaptic nerve terminals⁶⁵ and probably serve a physiological role at high rates of stimulation.

Using whole-cell clamped hippocampal neurons, the rapid perfusion and withdrawal of AnTX produced a greater maximal stimulation of a given neuron than did ACh (Figure 4),⁴³

in keeping with the higher affinity of AnTX. These AnTX-elicited currents grew linearly with hyperpolarization from -10 to -100 mV, but rectification was observed at positive potentials. Similar rectification of AChR currents was also observed in PC12 cells,⁶⁶ but in that study, the rectification was attributed to Mg^{2+} . Our experimental solutions were nominally Mg^{2+} free and, therefore, we are very interested in the physiological development and role of such a phenomenon.

The identity of the AnTX-induced currents was confirmed using conventional nicotinic antagonists.

This nicotinic receptor was sensitive to the competitive antagonists d-tubocurarine and dihydro- β -erythroidine and the noncompetitive antagonist mecamylamine,⁸ but was resistant to ligands such as APV, DNQX, and bicuculline that are commonly used to characterize nonnicotinic receptors.⁸ Thus, we can assert confidently that the receptor population that responds to AnTX is a nicotinic receptor.

that the open times were briefer at hyperpolarized potentials than were expected, considering that the normal lifetime of peripheral AChRs opened by low concentrations of AnTX increased exponentially with hyperpolarization. Thus, the open times of neuronal channels activated by AnTX resemble those in the presence of open channel blockers at the peripheral AChR.^{26,31}

The evidence above for secondary antagonist actions of AnTX at the neuronal AChR, including shortened single-channel life-time and rapid termination of whole-cell currents, reinforces the need for future studies to understand the ion channel blocking and desensitizing effect of AnTX and analogs. In addition, single-channel studies using ACh and AnTX as nicotinic ligands showed that the central AChR is also subject to blockade by known peripheral AChR blockers; at the central AChR, MK-801 and phencyclidine produced a greater reduction of channel opening frequency than they did in the periphery, although these antagonists did elicit some degree of reversible channel blockade (flickering).^{42,61}

One explanation for the observation of lower AChR response rates and the need for higher concentrations of nicotinic agonist in neurons, as contrasted with muscle, is that AChRs are present in relatively

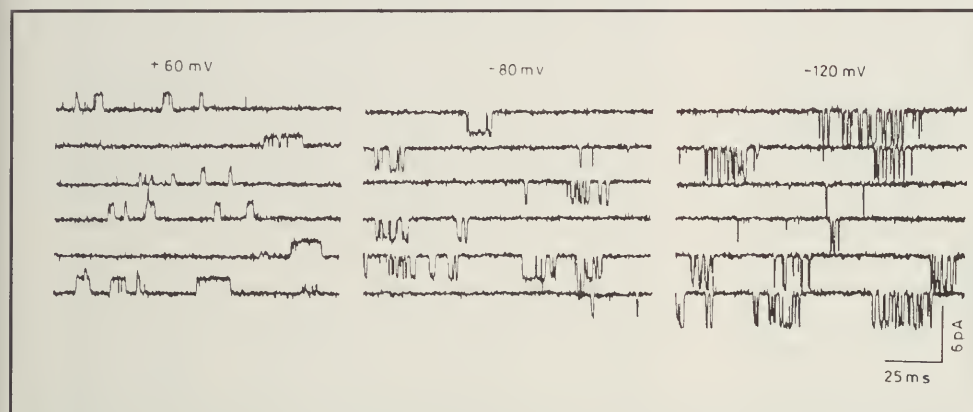


Figure 3. Single-channel currents recorded from rat fetal cultured hippocampal neurons when stimulated by AnTX (1 μ M). The recording was made at room temperature from an outside-out patch and the data were filtered at 2 kHz.

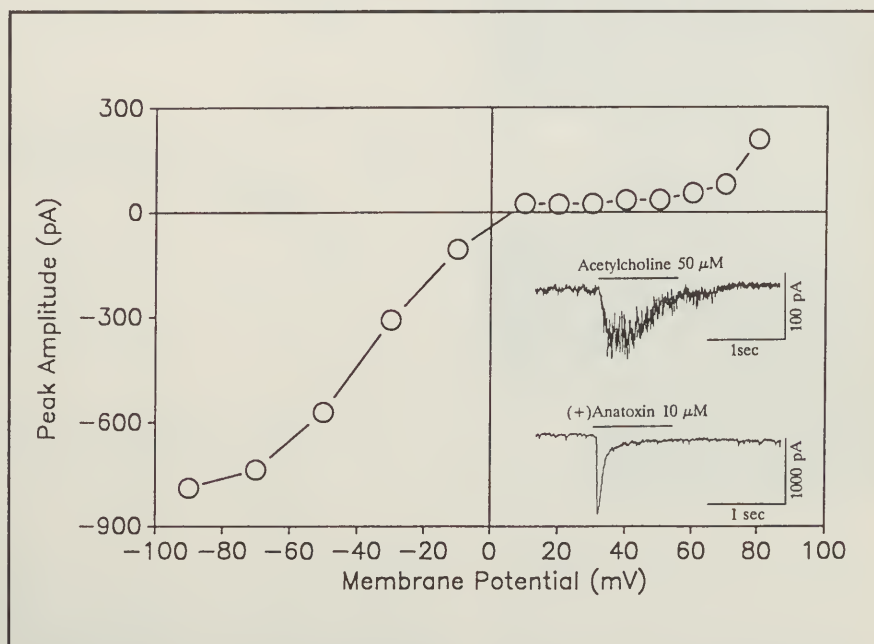


Figure 4. Conductance plot of peak whole-cell current amplitudes in response to AnTX (10 μ M) shows rectification in the first quadrant. Inset: Whole-cell clamp currents elicited from hippocampal neurons by ACh and (+)AnTX (notice the different ordinate scales).

Our studies indicate a close relationship between cell development and maturation of the nicotinic receptor (**Figure 5**). The current responses to AnTX (10 μ M) increased eight to ten-fold in amplitude during the first thirty days and peaked at thirty-five days.⁸ Although the response to ACh was considerably weaker than that to AnTX, the ACh-induced currents were augmented by pretreatment of the preparation with the organophosphorus agent VX (**Figure 6**). The currents were also somewhat prolonged, as is anticipated during cholinesterase inhibition. Thus, it is probable that acetylcholinesterase plays a significant role in ACh elimination during *in vitro* development. The bottom trace in **Figure 6** shows brief currents elicited in the presence of VX. The magnitude of these currents is substantial, even when compared with responses of applied agonist above. VX is known

to evoke presynaptic depolarization and transmitter release.^{67,68} Here, the brief currents indicate the formation of synapses onto the recording neuron. Collectively, these data demon-

strate the development of cholinergic transmission between neurons that is mediated by nicotinic receptors and terminated by cholinesterase.

An abundance of nicotinic AChRs, responsive to AnTX, are available for study with carefully selected electrophysiological techniques. At least four different functional types of nicotinic AChRs have been identified from these and other studies: (1) α BGT sensitive AChR, present in frog muscle endplates and *Torpedo* electric organs; (2) mecamylamine-sensitive and APV-insensitive AChRs on retinal ganglion cells; (3) d-tubocurarine- and dihydro- β -erythroidine-sensitive AChR on neuronal hippocampal pyramidal cells⁸; and (4) the AChR with rectifying outward current in nominally Mg^{2+} -free medium. Moreover, the presence of presynaptic receptors on the hippocampal nerve terminals may constitute an additional class of AChR in the brain. The progress in understanding the nicotinic AChR of the brain has been facilitated with the use of AnTX.

Current medical research indicates that the number of nicotinic AChRs is altered in addiction and in disease and pathology of the brain. For example, nicotine is the most prevalent of addictive drugs and through its association with tobacco smoking, contributes significantly to pulmonary pathologies. The need to treat diseases affecting the nicotinic AChR is great, but therapeutic options are few. Through

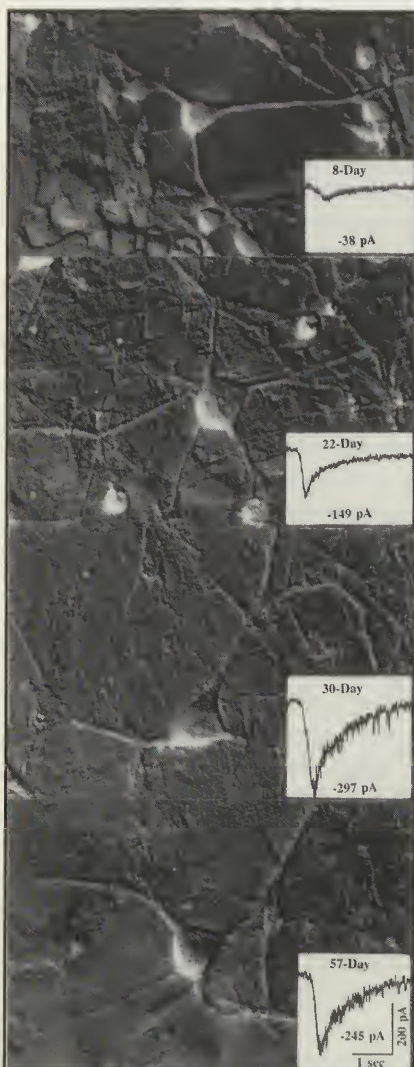


Figure 5. Development of nicotinic AChR responses in cultured neurons. Rat hippocampal neurons were maintained in culture for up to two months. Patch clamp recordings, in the whole-cell configuration, with microperfusion of AnTX and ACh were used to monitor the presence of neurotransmitter receptors throughout the phases of growth and maturation.

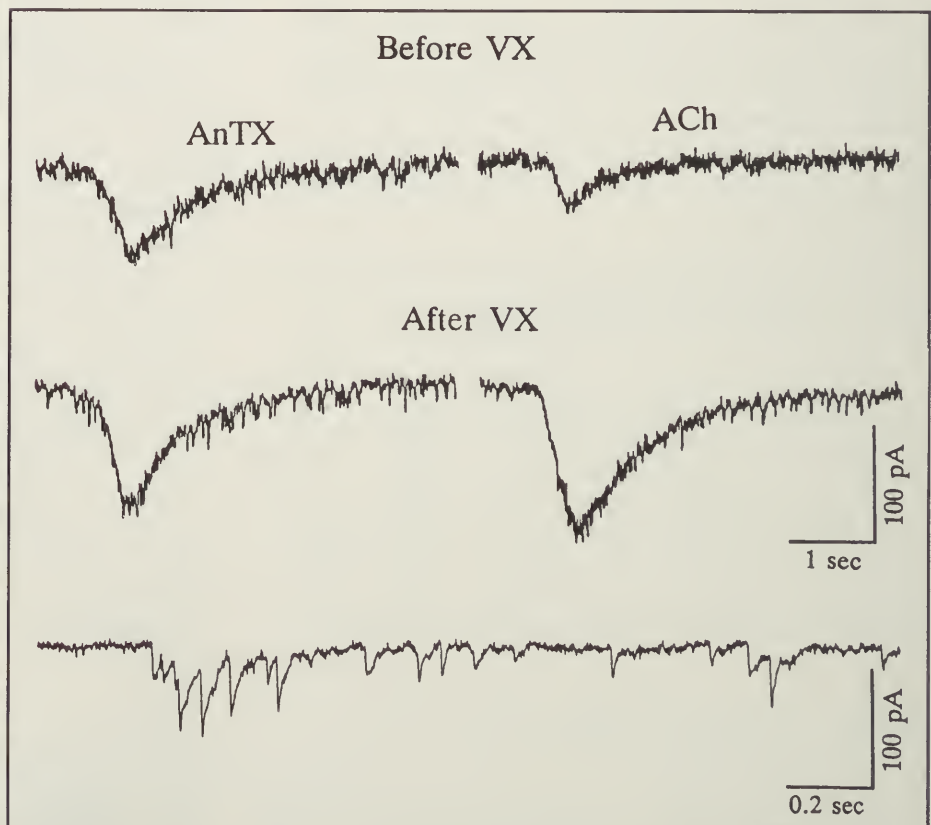


Figure 6. Evidence for the function of nicotinic cholinergic synapses between hippocampal neurons in culture. Top row: AnTX (10 μ M) and ACh (100 μ M) were superfused onto the neurons. Middle row: Neurons were treated with the irreversible cholinesterase inhibitor VX (2 μ M) and then treatments in the top row were repeated. Bottom row: Synaptic currents elicited by VX (0.1 μ M); no agonists were applied.

careful correlation of structure-activity relationships of AnTX analogs, we may ultimately be led to the development of diagnostic and therapeutic drugs with specific nicotinic agonist or antagonist activities in the central nervous system that would be of major importance in the treatment of Alzheimer's disease.

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Our colleagues who have participated or are now participating in the studies of the nicotinic receptor are at University of Maryland: CN Allen, Y Aracava, M Alkondon, ACS Costa, SS Deshpande, P Kofuji, B Marrow, EFR Pereira, E Rocha, R Rozental, GT Scoble, and MA Zelle; at Medical College of Georgia: RS Aronstam and L Narayanan; at the University of Bath, U.K.: S Wonnacott, DRE MacAllan, J Irons, S Jackman, CM Rapier, GG Lunt, and P Thomas; and at the Institute of Psychiatry, De Crespigny Park, London, U.K: IP Stolerman. AnTX analogs were designed and synthesized at University of California Berkeley: H Rapoport, AMP Koskinen, MH Howard, ML Morningstar, and FJ Sardina.

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The contents embodied in this manuscript describing our studies could never have been developed without the vision and magnanimity of Professor J. Dennis, our former dean, who fostered the recruitment of outstanding faculty and enabled us to have the necessary facilities for the fulfillment of our dreams and professional careers as scientists and scholars. The support for basic sciences research, which resulted in a high quality department with productivity and extramural support that is highly competitive in the university community of this country, is a total credit to him.

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Information for AUTHORS

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All material, including references, tables, and legends, must be double-spaced. Pages should be numbered. (All abbreviations should be spelled out on first use.) The original manuscript plus one copy should be submitted on standard (8.5" x 11") bond paper. If at all possible, an IBM-compatible disk should be included, with the manuscript entered in a WordPerfect, Multimate, Wordstar, or ASCII format; the transmittal letter should identify the format used.

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1. Stevens MB. The clinical spectrum of SLE. Md Med J 1991; 10:875-85.

2. Ropes MW. Characteristics, manifestations, and pathologic findings. In: Ropes MD, ed. Systemic Lupus Erythematosus. Cambridge, MA: Harvard University Press. 1976; 50-4.

- **Tables**—Tables should be typed on separate sheets of paper, be numbered, and have a brief descriptive title. Data presented in tables should be self-explanatory and should supplement, not duplicate, the text; the Editor reserves the right to edit tables. Authors should be sure that statistics are consistent in both tables and text.

- **Illustrations**—Illustrations include material that cannot be set in type. Photographic material must be submitted as high-contrast, glossy prints. Drawings and graphs must be done professionally in india ink on high-grade white drawing paper or be computer generated. Identification—including figure number, the title of manuscript, the name of

corresponding author, and arrow indicating top—should be typed on a gummed label and affixed to the back

Checklist

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- ☐ IBM-compatible disk in WordPerfect, Multimate, Wordstar, or ASCII.
- ☐ Everything double-spaced.
- ☐ Letter of transmittal, signed by all authors, that includes release of copyright, statement of authorship responsibility, title and affiliation of all authors, and identification and phone number of corresponding author.
- ☐ Thirty to fifty word synopsis.
- ☐ Permission-to-borrow letters for any previously published illustrations or tables.

of each illustration. Legends for illustrations should be typed on a separate page with numbers corresponding to those on the photographs or drawings. Recognizable photographs of patients are to be masked and should carry with them written permission for publication. Cost of printing color photographs must be borne by the author.

- **Permissions**—Material taken from other sources must be accompanied by written permission from both author(s) and publisher allowing the MMJ to reproduce the information/figure.

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Accepted manuscripts become the permanent property of the MMJ and are subject to copy editing. (The *Chicago Manual of Style* and the unabridged *Random House Dictionary of the English Language* are used as style guides.) The corresponding author is sent a reprint order form and galley proofs. S(he) then has 48 hours in which to make minor changes and clear all corrections and changes with co-authors; if proofs are not returned by the specified date, they will be considered approved as typeset. ■

Pancreas Transplants

Doctor, my daughter has had diabetes for ten years. She is now twenty-five years old. She has never had her blood glucose under very good control because she does not like to check her blood glucose and refuses to take insulin more than once a day. I have heard that patients can receive pancreas transplants to cure their diabetes. Is this true, and if it is, how would my daughter qualify to receive one?

To begin, pancreas transplants are not done routinely to cure diabetes. Two kinds of transplants are being performed—one entirely on a research basis and a second in a selected group of patients. Since a pancreas transplant is the only cure for diabetes, the level of interest in these procedures is extremely high, and knowledge of the current status of pancreas transplantation is important.

The first type of transplant is the islet cell transplant. In this procedure, islet cells are isolated from the rest of the donor's pancreatic tissue, so that the diabetic recipient receives only those cells that make insulin, plus other islet-cell-derived hormones (glucagon, somatostatin). This procedure is being tested worldwide, but is currently purely a research procedure. The source of the islet cells may be from a cadaver or from fetal tissue, and some research is being done with pig islets. It is difficult, if not impossible, to isolate enough islet cells from human donors to graft into the diabetic patient to cure diabetes. Problems with the procedure include inefficient and incomplete purification of islet cells, the need for immunosuppression to maintain the graft, and difficulty in identifying the ideal site for grafting. Several approaches have been tried including injection into the portal vein, placement of the islet

cells into a bag that will allow insulin out but not antibodies in, and even injection into the brain. Most investigators feel that science is many years away from perfecting this technique.

The second type of transplant is the whole pancreas transplant. This procedure has been done over a thousand times, and the techniques have now become standard clinical practice in many institutions. The indications for transplant have so far been quite specific. Except for research purposes, all patients receiving a pancreas transplant will receive a simultaneous kidney transplant or will already have had a kidney transplant. The procedure requires immunosuppression, as does a kidney transplant. Therefore, adding the pancreas to the graft does not increase long-term risk to the patient compared with the kidney graft alone. The survival rate of pancreas transplants is now about 70 percent. It is a difficult surgical procedure that should only be performed by an experienced surgeon.

When successful, the patient is cured of diabetes as well as renal failure. Patients who receive these transplants usually have other complications of diabetes in addition to kidney failure. Studies have shown a benefit for diabetic neuropathy but no improvement in diabetic retinopathy, although it is hoped that long-term follow-up will demonstrate a beneficial effect.

Combined kidney-pancreas transplants and second-stage pancreas transplants are being performed at the University of Maryland.

JAMES H. MERSEY, M.D.
Editor



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Imaging Case of the Month

A 78-year-old male, senior judge, had a three-year history of inability to express himself, short-term memory loss, and some comprehension problems since an operation for cancer of the prostate. There was no other significant past medical history or family history of dementia. The physical examination was unremarkable and the patient was not on any medication at the time. Both computed tomography (CT) and magnetic resonance imaging (MRI) scans were obtained and were within normal limits for age. A radionuclide brain scan was performed. Four representative transaxial images are shown below (Figure 1). A clinically similar disease is shown in Figure 2. A normal patient is shown in Figure 3.

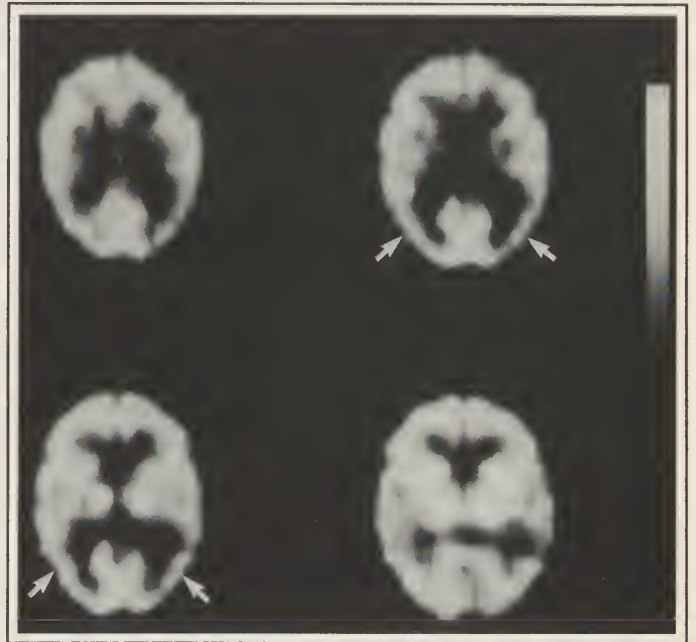


Figure 1.

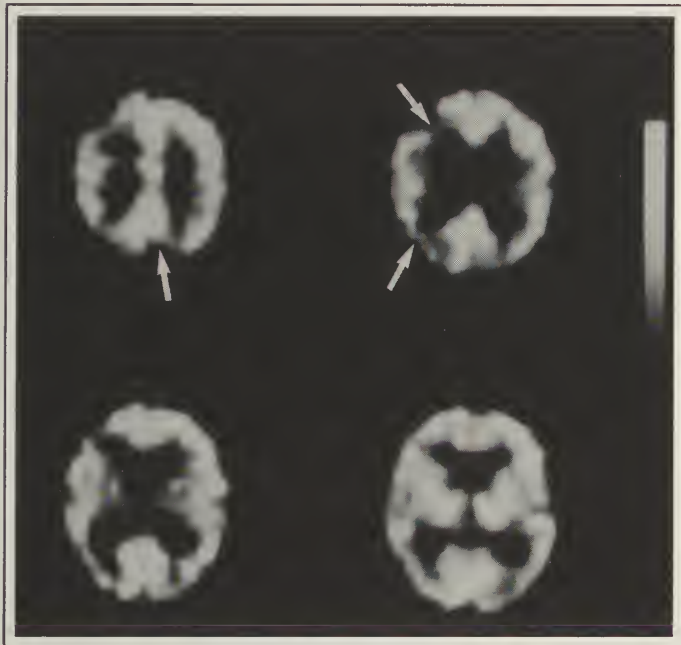


Figure 2.

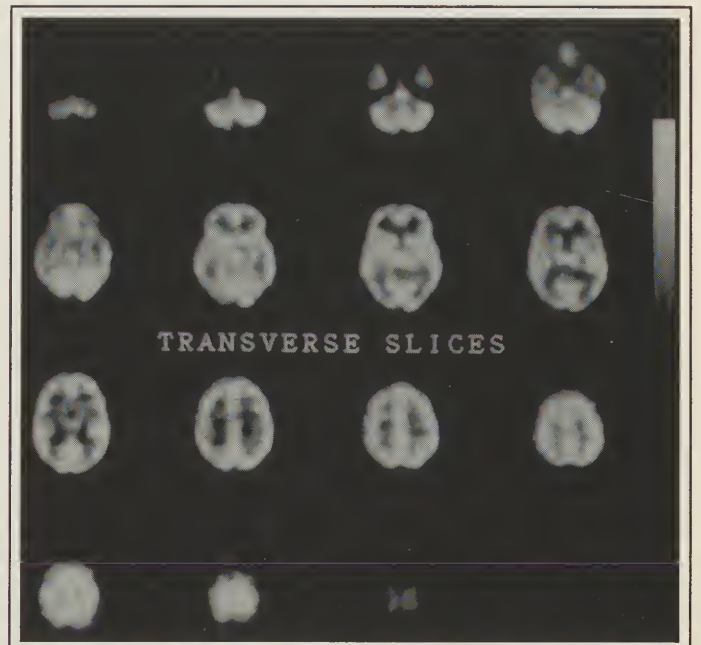


Figure 3.

Imaging Case of the Month

Alzheimer's disease

Figure 1. The Tc99m-HMPAO brain SPECT (single photon emission computed tomography) images demonstrate bilaterally decreased perfusion in temporoparietal lobes, characteristic of Alzheimer's disease (arrows).

Figure 2. Multiple areas of decreased perfusion in the right frontal, right parietal, and left parietal lobes in a patient with multifocal infarct dementia (arrows).

Figure 3. Normal study in transaxial section.

Alzheimer's disease, the leading cause of dementia (65.9 percent of all dementia),¹ is a disease of gradual onset with progressive deterioration of intellectual and cognitive functions. Histologic studies reveal an excessive number of senile plaques and neurofibrillary tangles. The neuropeptide somatostatin is markedly reduced in the cerebral cortex and may be reduced in the cerebrospinal fluid (CSF).

In one study, approximately 10.3 percent of a community population over the age of 65 years had presumed Alzheimer's disease. Of those, 3 percent of the 65 to 74 year olds, 18.7 percent of the 75 to 84 year olds, and 47.2 percent of those over 85 years of age had Alzheimer's disease. These data suggest that the prevalence rate is strongly age related. The public health impact will continue to grow with increasing longevity of the general population.²

When intensive evaluation, including an extensive diagnostic workup, is performed, a 90 percent diagnostic accuracy for Alzheimer's disease can be reached.³

The newer imaging technologies in the diagnosis of Alzheimer's disease include MRI, PET (position emission tomography), and SPECT (single photon emission computed tomography) scans. Dilated cortical sulci with increased iron deposition—most prominently seen in the temporoparietal cortex bilaterally—are seen on MRI scans.⁴ There is reduction in metabolism in the parietal cortex on PET using fluorine-18 glucose. However, the memory change may precede measurable metabolic reduction. SPECT—using Tc99m-HMPAO—can be used to measure regional cerebral blood flow. As also shown in our case, there is a decrease in regional blood flow involving the temporoparietal lobes bilaterally in Alzheimer's disease. The sensitivity of SPECT in the diagnosis of Alzheimer's disease was found to be approximately 83 percent, and specificity was 60 percent in a study of thirty-nine patients.⁵ These results may improve with experience.

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EDWALDO E. CAMARGO, M.D. is a radiologist in the Department of Radiology, Johns Hopkins Hospital, Baltimore, MD.

EDGAR C. FEARNOW, M.D.
Department Editor

Imaging Case of the Month

Imaging Case of the Month is a new department of the *Maryland Medical Journal* which will be featured on a regular basis. Coordinated by the Maryland Radiological Society, the cases will review a broad range of diseases and pathological processes of interest to a wide range of specialists. Physicians interested in submitting cases for publication consideration should contact the Department Editor.

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Board of Physician Quality Assurance Actions

In the matter of
Jeffrey M. Davis, M.D.
before the
**Maryland Board of
Physician Quality Assurance**

Consent order

After reviewing certain information that came to its attention, the State Board of Physician Quality Assurance (the board), on November 12, 1991, voted to charge Jeffrey M. Davis, M.D. (the respondent) under the Maryland Medical Practice Act (the act), *Md. Health Occ. Code Ann.* §14-404(a)(8) and (28) (1991 Replacement Volume).

The pertinent provisions of the act provides the following:

- (a) Subject to the hearing provisions of §14-405 of this subtitle, the board on the affirmative vote of a majority of its full authorized membership, may reprimand any licensee, place any licensee on probation, or suspend or revoke a licensee if the licensee
 - (8) Is addicted to, or habitually abuses, any narcotic or controlled dangerous substance as defined in Article 27 of the code;
 - (28) Sells, prescribes, gives away, or administers drugs for illegal or illegitimate medical purposes.

The board voted the charges against the respondent based upon the fact that he was arrested on November 5, 1991 and charged with possession of controlled dangerous substances. Further, the board acted based upon the fact that the respondent's privileges at Sacred Heart Hospital in Garrett County, Maryland were summarily suspended on November 12, 1991. Prior to the issuance of a charging document against him, the respondent advised the board that he was willing to surrender his Maryland medical license pending the resolution of the criminal case.

On December 9, 1991, a majority of the full authorized membership of the board voted to accept the respondent's offer of a revocable letter of surrender pending the resolution of his criminal case. The board took into account the respondent's full cooperation with the board in deciding to accept the letter of surrender. The respondent's surrender of his license to practice medicine in the state of Maryland was to stay in effect pending the resolution of all criminal charges against him in the state of Maryland.

On February 18, 1992, the respondent appeared in the District Court of Maryland for Garrett County. The respondent was sentenced by Judge Turney on his guilty plea to a single count of possession of marijuana in case #000760X4. The remaining charges against the respondent were dismissed by the state as there was no evidence that any of the other substances seized were controlled dangerous substances. The respondent was fined \$110.00 and granted probation before judgment pursuant to Article 27, §641 of the *Annotated Code of Maryland*. The court also found that there was no evidence showing a relationship between the offense and the respondent's practice of medicine.

On March 11, 1992, a settlement conference was held before the case resolution conference of the board. The following board members were present: J. Andrew Sumner, M.D., acting chief case resolution conference officer and Cheryl E. Winchell, M.D. Also present were the respondent; Stephen C. Wilkinson, Esquire, counsel for the respondent; Steven P. Lemmey, Esquire, assistant attorney general and administrative prosecutor; C. Frederick Ryland, Esquire, assistant attorney general, counsel to the board; and Sylvia J. Anderson, paralegal. The case resolution conference recognized the respondent's full and complete cooperation with the board in this matter and recommended that this case be resolved by entering into a consent order. The board, at its meeting on March 25, 1992, considered the case resolution conference's recommendation and voted to accept this consent order.

As a result of the case resolution conference, the parties have agreed to enter into this consent order.

Findings of fact

1. At all times relevant to these charges, respondent was licensed to practice medicine in the state of Maryland.
2. On or about November 5, 1991, the respondent was arrested and charged with possession of marijuana and other controlled dangerous substances.
3. On December 5, 1991, the respondent voluntarily surrendered his license to practice medicine in the state of Maryland pending the resolution of all criminal charges against him in the state of Maryland.
4. On February 18, 1992, in the District Court of Maryland for Garrett County in Case #000760X4, the respondent pled guilty to a single count of possession of marijuana. The respondent was fined \$110 and received probation before judgment, for the single count of possession of marijuana. All other charges against the respondent were dismissed by the state.
5. The respondent's plea of guilty to possession of marijuana and his being fined and placed on probation by the District Court of Maryland for Garrett County, is discipline by a court for an act that would be grounds for disciplinary action under §14-404(a)(21).
6. The respondent has fully cooperated with the board's investigation of this matter. The respondent has already provided the board with evidence that he has voluntarily entered into a contract with the Physician Rehabilitation Program at Med Chi and has been following their recommendations.

Conclusions of law

Based on the foregoing findings of fact, the board concludes as a matter of law, that respondent was disciplined by a licensing or disciplinary authority or convicted or disciplined by a court of any state or country or disciplined by any branch of the United States uniformed services or the Veter-

Board of Physician Quality Assurance Actions

ans' Administration for an act that would be grounds for disciplinary action under this section. *Md. Health Occ. Code Ann.* §14-404(a)(21) (1991 Replacement Volume.)

Order

Based upon the foregoing findings of fact and conclusions of law, it is this 25th day of March 1992, by an affirmative vote of the majority of the full authorized membership of those members of the Board of Physician Quality Assurance of Maryland, who considered this case, hereby

ORDERED, that the board, pursuant to its authority under *Md. Health Occ. Code Ann.*, §14-406, DISMISSES the charges brought against the respondent under *Md. Health Code Ann.* §14-404(a)(8) and (28); and it is further

ORDERED, that the respondent's license to practice medicine in the state of Maryland is SUSPENDED; and it is further

ORDERED, that the suspension of respondent's license to practice medicine in the state of Maryland shall be IMMEDIATELY STAYED and respondent will be placed on PROBATION subject to the following conditions for a period of two years:

1. The respondent agrees to comply with all conditions of his physician rehabilitation advocacy contract. Incorporated herein as Exhibit A is a release that respondent signed authorizing the Committee on Physician Rehabilitation of the Medical and Chirurgical Faculty of Maryland to release any and all information to the board whenever the board requests any information.
2. The respondent will make arrangements for the Committee on Physician Rehabilitation of the Medical and Chirurgical Faculty of Maryland to submit quarterly reports to the board indicating whether respondent has complied with all reasonable recommendations. The reports are due July 1, 1992; October 1, 1992; January 1, 1993; April 1, 1993; July 1, 1993; October 1, 1993; January 1, 1994; and April 1, 1994.
3. The respondent will make arrangements for E.R. McDonald, Jr., M.D., vice president of Sacred Heart Hospital, or his superior, should he change his employment, to submit quarterly reports to the board indicating whether respondent is competently practicing medicine. Reports are due July 1, 1992; October 1, 1992; January 1, 1993; April 1, 1993; July 1, 1993; October 1, 1993; January 1, 1994; and April 1, 1994.
4. The respondent will submit to separate random drug screens that the board may require.
5. The respondent shall not violate any other provisions of the act.
6. The respondent shall not engage in the conduct that led to the criminal charges by the court.
7. The respondent shall practice in accordance with the laws governing the practice of medicine in Maryland; and it is further

ORDERED, that if the board receives a report that the respondent is a danger to the public health, safety, or welfare, the board, WITHOUT PRIOR NOTICE OR AN OPPORTUNITY TO BE HEARD, MAY LIFT THE STAY OF SUSPENSION OF THE RESPONDENT'S LICENSE, provided that the respondent is given immediate notice of the charges and an opportunity to be heard thirty days after requesting same in accordance with State Government Article, §10-405; and be it further

ORDERED, that if the respondent violates any other term of the respondent's probation, the board, after notice and a hearing, and a determination of violation, may lift the stay of suspension of the respondent's license or may impose any other disciplinary sanctions if deemed appropriate, said violation of probation being provided by a preponderance of evidence; and be it further

ORDERED, that the respondent's request that his Maryland medical license be REINSTATED is GRANTED subject to the conditions of this order; and be it further

ORDERED, that the respondent will be responsible for all costs incurred under this consent order; and be it further

ORDERED, that this consent order is considered a public document pursuant to *Md. State Gov't Code Ann.* §10-611 *et seq.*

ISRAEL H. WEINER, M.D., Chairperson
Maryland Board of Physician Quality Assurance

Consent

By this consent, I hereby accept and agree to be bound by the foregoing order and its conditions and restrictions, consisting of ___ pages.

1. By signing this consent, I hereby submit to the foregoing order as a resolution of this case.
2. I acknowledge the validity of this order as if made after a hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by law.
3. I recognize that I am waiving my right to appeal any adverse ruling of the board that might have followed any such hearing. By this consent I waive all such rights.
4. I understand that if I present a danger to the public health, safety, or welfare, the board may, WITHOUT PRIOR NOTICE AND AN OPPORTUNITY FOR ME TO BE HEARD, vacate the stay of suspension, reinstate the suspension, and reinstitute formal proceedings against my license to practice medicine in Maryland.
5. I, Jeffrey M. Davis, M.D., have read this consent order and have carefully reviewed each and every part with my attorney, Stephen C. Wilkinson, Esquire. I understand it and voluntarily agree to it.

JEFFREY M. DAVIS, M.D.
STEPHEN C. WILKINSON, ESQUIRE

Board of Physician Quality Assurance Actions

**In the matter of
John M. Hamilton, M.D.
before the
Maryland Board of
Physician Quality Assurance
Final order**

Having reviewed certain information which came to its attention, the Board of Physician Quality Assurance (the board), on June 27, 1990, voted to charge John M. Hamilton, M.D. (the respondent) under the Maryland Practice Act (the act), *Md. Health Occ. Code Ann.* (HO) §14-504(a)(3) (1988 Repl. Vol.).

After further consideration, on October 25, 1991, the board charged that the respondent

Is guilty of ... unprofessional conduct in the practice of medicine; [HO §14-504(a)(3)]; and

Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this state; [HO §14-504(a)(22)].

The respondent was notified of these charges on October 25, 1991 through service of his attorney, George L. Russell, Jr., Esquire. A hearing was scheduled for this matter for January 28, 1992 (prehearing January 22, 1992.)

On November 13, 1992, a settlement conference was held before the case resolution conference of the board. The following board members were present: J. Andrew Sumner, M.D., chief case resolution conference officer; Frank A. Gunther, Jr.; and Cheryl Winchell, M.D. Also present were the respondent; George L. Russell, Jr., Esquire, counsel for the respondent; Robert J. Gilbert, Esquire and Nancy P. Tennis, Esquire, assistant attorneys general and administrative prosecutors; Carl F. Ameringer, assistant attorney general and deputy counsel, Department of Health and Mental Hygiene; and C. Frederick Ryland, Esquire, assistant attorney general, counsel to the board.

Subsequent to this conference, the Office of the Attorney General (the state) and the respondent agreed to proceed in the following manner:

1. The respondent agreed to waive his opportunity to proceed with a formal evidentiary hearing as authorized under HO §14-405 and the Administrative Procedure Act, *State Gov't. Code Ann.* §10-205 *et seq.* This hearing had been scheduled for January 28, 1992 before the Office of Administrative Hearings.
2. The state and the respondent entered into a consent agreement, which was jointly executed by the respondent and the state on January 28, 1992, respectively. In this consent agreement, state and the respondent stipulated to an agreed statement of facts and conclusions of law, which summarized the evidence, expert testimony, and treatment records involving patient A in the above-captioned case. The state and the respondent also stipulated that the

respondent had committed a prohibited act under the Maryland Medical Practice Act, i.e., that he was guilty of unprofessional conduct in the practice of medicine, under HO §14-504(a)(3) (1988 Repl. Vol.). The respondent agreed to produce no evidence contradicting the materials stated in the agreed statement of facts and conclusions of law. The respondent admitted to the truth and validity of the agreed statement of facts and conclusions of law, as if issued after the conclusion of a formal evidentiary hearing where the respondent would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on his own behalf, and to all other substantive and procedural protections provided by the laws of the state of Maryland.

3. The respondent agreed and understood that the board would find that he had committed a prohibited act under the Maryland Medical Practice Act, i.e. that he was guilty of unprofessional conduct in the practice of medicine under HO §14-504(a)(3) (1988 Repl. Vol.) based on the agreed statement of facts and conclusions of law contained in the consent agreement. With respect to the disposition of this matter, the state and the respondent agreed to make separate recommendations to the board for the board's consideration at the board's next regularly scheduled meeting, Wednesday, February 26, 1992. The state and the respondent reserved the right to make appropriate argument in regard to the disposition of this matter before the board.
4. The respondent agreed that he would submit to whatever disposition the board ordered. The respondent understood that all or any portion of the consent agreement that he had executed may be used or incorporated in any final order issued by the board pursuant to HO §14-406. Further, the respondent agreed to waive his right to appeal any adverse ruling of the board and acknowledged the legal authority and the jurisdiction of the board to initiate these proceedings and to carry out any action authorized by the act and the Administrative Procedure Act.
5. The state agreed to dismiss charges under HO §14-504(a)(22) of the act, i.e., that the respondent failed to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this state.
6. The respondent acknowledged that he was represented by legal counsel and had the opportunity to consult with counsel before entering into and executing the consent agreement. In executing the consent agreement, the respondent admitted to the truth and validity of the contents of the background, settlement agreement, agreed statement of facts, and conclusions of law as contained in the consent agreement.

Considered by the board at its February 26, 1992 meeting was the consent agreement, executed by the respondent and

Board of Physician Quality Assurance Actions

Mr. Russell, witnessed by a notary public on January 28, 1992; and executed by Mr. Gilbert and Mrs. Tennis on behalf of the state on January 29, 1992. After hearing argument from the respondent and the state on the issue of the disposition of this matter and considering the stipulation of evidence presented before it, the board members issued the following decision. The decision is based on clear and convincing evidence and issued on the affirmative vote of a majority of the authorized board members hearing this case.

The consent agreement, containing background, settlement agreement, agreed statement of facts, and conclusions of law, consisting of eleven pages, executed on January 28, 1992 by the respondent, and January 29, 1992 by the state, considered by the board, is incorporated as an exhibit.

Findings of fact

On the basis of clear and convincing evidence, the board finds as follows:

- A. At all times relevant hereto, the respondent was and is licensed to practice medicine in the state of Maryland. The respondent is a 68-year-old psychiatrist who has maintained a limited private practice in Baltimore, Maryland since 1960, and is presently deputy medical director of Psychiatric Services of the American Psychiatric Association (APA). The respondent, in part, authored the *APA Peer Review Manual*, and directed its revisions in 1980 and 1985.
- B. On or about March 22, 1988, Patient A, a 40-year-old female, was hospitalized in the Howard County General Hospital (HCGH) Psychiatric Unit after presenting in the HCGH emergency room with depression. Previously, the patient had received inpatient psychiatric treatment at Johns Hopkins Hospital. While at that institution, the patient reported having been sexually assaulted by a fellow patient. The patient had an extensive prior psychiatric and medical history, including recurrent depression, Multiple Personality Disorder (MPD), suicidal ideation, and congenital heart abnormalities.
- C. The respondent was the attending, on-call physician at HCGH at the time Patient A was admitted. Patient A was hospitalized at HCGH for approximately one month. After the patient was discharged from HCGH, the respondent provided outpatient psychiatric care to the patient at his office in Columbia, Maryland.

The patient was admitted to the HCGH Psychiatric Unit on two additional occasions in 1988: July 3 through 7, wherein the patient was diagnosed with depression with suicidal ideation; and August 20 through September 17. On this admission, the patient was again diagnosed with major depression with suicidal ideation, dissociative disorder, MPD, and hypertrophic cardiomyopathy. In his discharge summary of the patient, dictated September 17, 1988, the respondent stated that

At the time of her most recent admission, she had been

experiencing an exacerbation in her dysphoric feelings, depression, anorexia, sleep disturbance, and suicidal ideation and felt, on the evening of that admission, that she would be unable to control her suicidal impulses and that she was rather rapidly disintegrating.

- D. The respondent provided psychiatric treatment to Patient A at his office during the period April 1988 through June 1989.
- E. During the above period, and during 1990, the respondent also prescribed various psychoactive and psychotropic medications for patient A, including Xanax, Fiorinal, and Lorazepam.
- F. During the period in which the respondent provided psychiatric treatment to Patient A in his office, April 1988 through June 1989, and afterward, during the period June 1989 through February 1991, the respondent became involved in and maintained an intimate relationship with Patient A. During this period, the respondent engaged in inappropriate physical and sexual acts with Patient A; and became involved in an emotional, social, and romantic relationship with Patient A. As part of this relationship, the respondent kept in close social contact with the patient, visiting her in her home, accompanying her to social events in public, and providing companionship to the patient.
- G. On or about November 1988, the patient contacted Rev. David W. Rogers in regard to obtaining housing, and during that conversation, advised him that she was emotionally and romantically involved with the respondent, and that the respondent had engaged in intimate, sexual activity with her during the course of the psychotherapeutic relationship. In December 1988, Rev. Rogers contacted the respondent and expressed concern over the nature of the respondent's behavior and actions toward the patient. The respondent acknowledged to Rev. Rogers that he (the respondent) had "crossed some lines," and had engaged in inappropriate contact with the patient of a physical/sexual nature. During their conversation, the respondent agreed to transfer the care of the patient to another psychotherapist. Despite this representation to Rev. Rogers, however, the respondent continued to provide psychiatric treatment to the patient on an outpatient basis until June 1989.
- H. On or about May 16, 1990, the respondent attended the American Psychiatric Association Convention in New York City. While at the convention, the patient stayed with the respondent in his hotel room. The patient subsequently advised Rev. Rogers of this incident. Rev. Rogers then contacted the respondent and scheduled a meeting with the respondent and the patient for May 23, 1990. During the meeting, Rev. Rogers strongly advised the respondent of the destructive nature of the respondent's actions in carrying on a continuing relationship with the patient. The respondent again admitted that he

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had engaged in an intimate, personal, romantic relationship with the patient.

- I. On or about June 11, 1990, the respondent was interviewed by an investigator with the Board of Physician Quality Assurance. In that interview, the respondent admitted that he had engaged in a sexual relationship and a long-term social relationship with the patient wherein the respondent visited the patient in her home and accompanied her in other social activities.
- J. The respondent terminated his relationship with Patient A in February 1991.
- K. The respondent engaged in unprofessional conduct in the practice of medicine in that the respondent engaged in sexual contact and an inappropriate emotional, social, and romantic relationship with Patient A under the above circumstances. Sexual contact and/or a romantic relationship concurrent with the psychiatrist-patient relationship is unethical and is unprofessional conduct in the practice of medicine. Sexual contact and/or a romantic relationship between psychiatrist and patient is unethical because it violates psychiatrist-patient boundaries that are necessary for an effective therapeutic relationship, confuses the patient as to the nature and extent of those boundaries, tends to provide gratification to the psychiatrist at the patient's expense, and compromises the patient's trust in the integrity and objectivity of the therapist and perhaps future potential therapists as well. A psychiatrist who engages in sexual contact and/or a relationship with the patient seriously compromises the patient's welfare.
- M. The respondent has had a long and distinguished career in psychiatry. His career has been dedicated to public service. He served with honor and greatly improved the quality of care as superintendent at two of Maryland's public mental hospitals, Clifton T. Perkins and Spring Grove Hospital Centers. His contributions to the medical field of psychiatry are widely respected both in Maryland and nationally. Dr. Hamilton's case must be judged with credit in light of his public contributions, but also with censure under the strong ethical standards he advocated.

Conclusions of law

On the basis of clear and convincing evidence as detailed in the stipulations contained in the consent agreement and further detailed in the above findings of fact, the board concludes as a matter of law that the respondent is guilty of unprofessional conduct in the practice of medicine, under §14-504(a)(3) of the act (1988 Repl. Vol.).

Order

Based on the foregoing consent agreement, findings of fact, and conclusions of law pursuant to HO §14-406, it is on this 3rd day of March 1992, hereby

ORDERED, that the respondent's license to practice medicine in the state of Maryland is **SUSPENDED**; and be it further

ORDERED, that this suspension is immediately **STAYED** only with respect to the administrative practice of medicine, as approved by the board, but specifically to exclude direct patient care and the writing of prescription drugs; and it is further

ORDERED, that the respondent is placed on probation for five years, subject to the following conditions of probation:

- (1) The respondent shall participate in psychotherapy sessions with a board certified psychiatrist approved by the Maryland Psychiatric Society Peer Review Committee (the MPS PRC) at intervals determined to be clinically necessary by the psychiatrist; and
- (2) Said psychiatrist shall submit quarterly reports to the board regarding the status and progress of said psychotherapy; and it is further

ORDERED, that one year from the effective date of this suspension, the respondent may petition the board for a stay of suspension of his license with respect to the clinical care of male patients; and be it further

ORDERED, that in the event that any direct, face-to-face patient care is allowed by the board such care shall be provided subject to the following additional conditions of probation:

- (3) The respondent shall participate in monthly supervision of patient care by a psychiatric supervisor, who shall be a board certified psychiatrist selected by the MPS PRC;
- (4) Said psychiatrist shall submit quarterly reports to the board regarding the patient care delivered by the respondent;
- (5) The respondent shall be subject to and shall participate in an independent annual evaluation conducted by a board certified psychiatrist selected by the MPS PRC. The MPS PRC shall appoint a psychiatrist other than the ones selected for purposes described in paragraphs (1), (3), and (4) above. This evaluation would assess, in part, what, if any, treatment gains the respondent has achieved through psychotherapy in regard to psychiatrist-patient boundaries. This independent annual evaluation shall take place no later than one year after the date of this order and, thereafter, on an annual basis for the remainder of the period of probation;
- (6) The respondent shall be prohibited from treating female patients for a period of three years after this initial suspension of his licensure;
- (7) After a one-year period following his being allowed to treat female patients, the respondent shall be assessed for fitness to practice psychiatry without ongoing limitations or restrictions by the psychiatrist selected pursuant to the purposes described in paragraph (5) above. Said assessment shall be forwarded to the MPS PRC for review. The MPS PRC shall review said assessment and the quarterly reports described in paragraphs (2) and (4) above, and shall

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make appropriate recommendations to the board regarding ongoing limitations or restrictions. The board shall then determine whether the respondent shall be subject to said limitations or restrictions during the remainder of the period of probation;

- (8) The respondent shall pay all costs associated with the psychotherapy sessions and quarterly reports described in paragraphs (1) and (2) above; shall pay all costs associated with the monthly supervision of patient care described in paragraphs (3) and (4) above; and shall pay all costs associated with the independent annual evaluation described in paragraphs (5) and (7) above. If the respondent fails to pay said costs in a timely fashion, not to exceed 60 days, the psychiatrists providing said services shall notify the board. Failure to pay all costs associated with this probation shall result in a violation of this final order;
- (9) The respondent shall be subject to an annual peer review of his practice, conducted by the MPS PRC. The respondent shall pay all costs associated with this peer review. The MPS PRC shall submit a report to the board annually, after the peer review is conducted, regarding the results of said peer review.

The respondent shall receive a copy of said report and shall follow any recommendations made by the MPS PRC and endorsed by the board;

ORDERED, that for purposes of this final order, the psychiatrists described in paragraphs (1) through (9) above shall be immune from civil liability in accordance with HO §14-501 when performing the functions of a Medical Review Committee; and be it further

ORDERED, that the respondent shall practice medicine in accordance with the Maryland Medical Practice Act; and be it further

ORDERED, that FOUR YEARS AFTER THE BOARD STAYS THE SUSPENSION OF THE RESPONDENT'S LICENSE, the board will entertain a petition for termination of the respondent's probationary status and reinstatement of respondent's license to practice medicine in Maryland without any conditions or restrictions whatsoever. At that time, if the board determines that a termination of probation would not be appropriate, the board may impose other conditions of probation or EXTEND the duration of probation. If the respondent has complied with all conditions of probation, receives favorable reviews by his peers, and if there are no outstanding complaints against the respondent's practice, the board will reinstate the respondent's license; and be it further

ORDERED, that if the board receives a report that the respondent is a danger to the public health, safety, or welfare, the board, WITHOUT EITHER PRIOR NOTICE OR AN OPPORTUNITY TO BE HEARD MAY LIFT THE STAY OF SUSPENSION OF THE RESPONDENT'S LICENSE, provided that the respondent is given immediate notice of the charges and an opportunity to be heard thirty days after

requesting same in accordance with the State Government Article, §10-405; and be it further

ORDERED, that if the respondent violates any other terms of the respondent's probation, the board, after notice and a hearing, and a determination of violation, may lift the stay of suspension of the respondent's license or may impose any other disciplinary sanctions if deemed appropriate, said violation of probation being proved by a preponderance of evidence; and be it further

ORDERED, that this is a final order and as such is considered a PUBLIC document pursuant to State Government Article, *Annotated Code of Maryland*, §10-611 *et seq.*

ISRAEL H. WEINER, M.D., Chairperson
Maryland Board of Physician Quality Assurance

■ ■ ■
In the matter of
Glenn David Herman, M.D.
before the
Maryland Board of
Physician Quality Assurance

Consent order

Based on information received by the State Board of Physician Quality Assurance (the board), the board, pursuant to its authority under *Md. Health Occ. Code Ann.* §14-404, 14-301, 14-302 and the *Code of Md. Regulations* (COMAR) Title 10.32.07.02.03 and .04 issued to Glenn David Herman, M.D. (the respondent) a notice of intent to deny his registration to practice medicine in the state of Maryland on September 17, 1991.

The pertinent provisions of the Maryland Medical Practice Act (the act), *Md. Health Occ. Code Ann.* §14-301 and 14-302(1) provide

§14-301 *License Required.* Except as otherwise provided in this title, an individual shall be licensed by the board before the individual may practice medicine in this state.

§14-302 *Exceptions from Licensing.* Subject to the rules, regulations, and orders of the board, the following individuals may practice medicine without a license:

- (1) A medical student or an individual in a postgraduate medical training program that is approved by the board, while doing the assigned duties at any office of a licensed physician, hospital, clinic, or similar facility.

The pertinent provisions of the *Code of Maryland Regulations* (COMAR), Title 10.32.07.02.03 and .04, provide

.03 *Postgraduate Programs.* An unlicensed medical school graduate may practice medicine only in a postgraduate training program approved by the ACGME, or its required successor, and only under a written training program contract with the providing institution.

.04 *Registration.* (a) The chief of service of the institution providing the postgraduate training program, or his design-

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nee, shall register with the board each unlicensed medical school graduate within thirty days of the effective date of the training program contract between the institution and the unlicensed medical school graduate.

- (b) Registration shall be on a form approved by the board, and shall include the unlicensed medical school graduate's name, local address, date of birth, professional school, date of graduation, the name and department of the institution directly responsible for the postgraduate training program, and beginning and ending dates of the contract.
- (c) Registration shall remain valid for the term of the contract, as stated on the registration form.
- (d) Reregistration of an unlicensed medical school graduate shall be required for each renewal or extension of the postgraduate training program contract.
- (e) The chief of service of the institution providing the postgraduate training program shall notify the board, within thirty days, of any termination of a contract, other than by natural expiration, and of the reasons for the termination.

A registered unlicensed health care practitioner or an applicant to become a registered unlicensed health care practitioner is subject to discipline by the board pursuant to COMAR 10.31.07.01 through .03. The portions of COMAR relevant to this applicant provide

B. Revocation or suspension of right to practice medicine

- (1) After investigation, the commission may revoke or suspend an unlicensed medical practitioner's right to practice medicine in the state, or place him or her on probation on prescribed conditions, or reprimand him or her for any of the causes listed below as unprofessional conduct.
- (2) Causes
 - (a) Physical, mental, or professional incompetence; ...
 - (h) Addiction to the illegal use of a controlled dangerous substance, habitual abuse of any narcotic or controlled dangerous substance, as defined in Article 27, *Annotated Code of Maryland*, or other drugs in excess of therapeutic amounts or without valid medical indication.

On December 11, 1991, a case resolution conference regarding this case was held. Present were John F. Strahan, M.D., chief settlement officer; Frank A. Gunther, Jr.; Peter E. Dans, M.D.; Cheryl E. Winchell, M.D.; J. Andrew Sumner, M.D.; C. Frederick Ryland, board counsel; Steven J. Poliakoff, staff attorney; Charles F. Cichon, case manager; Steven P. Lemmey, assistant attorney general, Sylvia J. Anderson, legal assistant; Glenn David Herman, M.D., respondent; and Gill Cochran, Esquire, counsel for Dr. Herman. The conference recommended that this case be resolved by entering into a consent order.

Findings of fact

1. At all times relevant to these charges, the respondent was a resident of the state of Maryland who was practicing medicine as an unlicensed health care practitioner based

upon the registration requirements in the Maryland Medical Practice Act and COMAR.

2. The respondent was serving as a physician at the Harbor Hospital Center in Baltimore, Maryland as part of the medical residency program.
3. As an unlicensed health care practitioner, the respondent is subject to regulation and discipline by the Board of Physician Quality Assurance.
4. The respondent resides in Glen Burnie, Maryland.
5. On August 23, 1991, the respondent was arrested in his home in Anne Arundel County pursuant to a search warrant executed by the Anne Arundel police. In executing the search warrant, members of the Anne Arundel County police recovered an Express Mail package addressed to the respondent and the respondent's wife. The package contained approximately one ounce of marijuana. On January 6, 1992, the respondent appeared in the District Court of Maryland for Anne Arundel County and entered a guilty plea to a single count of misdemeanor possession of marijuana under Case Number 042562A2 known as the *State of Maryland v Glenn David Herman*. The respondent's guilty plea stemmed from his possession of marijuana on August 23, 1991 while at his home in Anne Arundel County, Maryland.

Subsequent to his guilty plea, the respondent was placed on probation by the District Court of Maryland for Anne Arundel County pursuant to Article 27, Section 641.

6. Subsequent to his arrest, the respondent entered into a contract with the Medical and Chirurgical Faculty of Maryland's Physician Rehabilitation Program. The respondent specifically consented to the board being provided information about his psychiatric and drug treatment, both with his private physicians and with Med Chi's Physician Rehabilitation Program.
7. The respondent's guilty plea to possession of marijuana in violation of Article 27 of the *Annotated Code of Maryland* and his admitted use of marijuana both provide grounds for the board to take disciplinary action with regard to his registration as an unlicensed health care practitioner in the state of Maryland.
8. The respondent has cooperated fully with the board, the investigators, Med Chi's Rehabilitation Program, and the Attorney General's Office in the investigation of this matter.

Conclusions of law

Based upon the above findings of fact, the board concludes as a matter of law, that the respondent was in violation of the Maryland Medical Practice Act and COMAR 10.31.07.02 (B)(2)(h).

Order

Based upon the foregoing findings of fact and conclusion of law, it is this 26th day of February 1992, an affirmative vote of the majority of the full authorized membership of those

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members of the Board of Physician Quality Assurance of Maryland who considered this case,

ORDERED, that the respondent's registration to practice medicine as an unlicensed medical practitioner in the state of Maryland is **SUSPENDED**; and that the suspension shall be immediately **STAYED** and the respondent is placed on probation for five years from the effective date of this ORDER subject to the following conditions:

1. The respondent, Glenn David Herman, M.D., will be permitted to register as an unlicensed medical practitioner, serving as a medical resident, pursuant to the Medical Practice Act and COMAR.
2. Except as provided in this ORDER, the respondent may not practice medicine in the state of Maryland.
3. The respondent may return to practice as a medical resident at Harbor Hospital Center immediately upon the execution of this consent order by the respondent and the board.
4. The respondent must remain an active participant in Med Chi's Physician Rehabilitation Program pursuant to the contract that he signed with them. The respondent must provide the board with his written consent for the board to obtain any and all information that is contained in Med Chi's Physician Rehabilitation Program file. The respondent's failure to successfully complete Med Chi's Physician Rehabilitation Program requirements will result in an immediate termination of his probation and the suspension shall become effective immediately upon the respondent's failure to comply with the Med Chi rehabilitation contract.
5. The respondent, at his expense, will submit to an annual psychiatric evaluation to be conducted by Steven W. Seibert, M.D. or another qualified psychiatrist as selected by the board.
6. The respondent shall sign releases allowing Dr. Seibert or a board selected substitute, to forward reports regarding respondent's treatment and its effectiveness to the board.
7. At the conclusion of his residency program at Harbor Hospital Center, the respondent shall enter into another one-year medical residency program either at the Harbor Hospital Center or at another approved medical residency program.
8. The respondent shall advise his supervisor at any residency program where he serves as a physician of the requirements of his Med Chi contract. The respondent shall provide each of his supervisors with a copy of this consent order with the board.
9. The respondent shall provide urine samples on a random basis pursuant to the Med Chi contract and separately to a designated agent for the board, if requested.
10. The respondent shall continue in his individual psychiatric treatment and will continue to attend Narcotics Anonymous or Alcoholics Anonymous meetings as directed by Med Chi's Physician Rehabilitation Program.
11. All urine screens provided by the respondent shall include screening for both marijuana and low-level traces of marijuana. The respondent's urines shall be observed at the time they are taken by the board's designated agent.
12. The respondent shall not, during the five years of this probation, write any prescription for himself or members of his family. In the event that the respondent writes a prescription for himself or a member of his family, he must, on an immediate basis, and in no event later than seven days from the date of the prescription, notify his assigned probation officer at the board of the facts and circumstances surrounding his writing a prescription for himself or a member of his family.
13. During the five years of his probation, the respondent shall not use any controlled dangerous substances nor shall he permit himself to remain in the presence of others who are voluntarily using controlled dangerous substances.
14. The respondent will notify the board, through his probation officer, of any adverse actions that are taken against him by any hospitals or medical facilities where he practices, within seven days of said actions. The respondent shall further advise his probation officer, within seven days, of any arrest or charges brought against him, including minor motor vehicle charges within seven days of his being charged.

It is further

ORDERED, that the board may, at its discretion, order one or more peer reviews of the respondent's practice as a medical resident at any time during the respondent's probation. The peer reviewers may conduct a chart review of the respondent's patients and interview the respondent or conduct any other aspects of a peer review; and be it further

ORDERED, that if the board has probable cause to believe that the respondent has violated the Maryland Medical Practice Act, or that the respondent presents a danger to public health, safety, or welfare, the board, without prior notice and an opportunity for a hearing, may vacate the stay of suspension and reinstate the suspension, provided that the respondent is given notice of the board's action and an opportunity for a hearing within thirty days after the respondent requests a hearing; and be it further

ORDERED, that this consent order is considered a public document pursuant to *Md. State Gov't Code Annotated* §10-611 *et seq* (1990 Cum. Supp.).

ISRAEL H. WEINER, M.D., Chairperson
Maryland Board of Physician Quality Assurance

Consent

By signing this consent, I hereby accept and agree to be bound by the foregoing consent order and its conditions and restrictions consisting of ten pages.

1. By signing this consent, I hereby submit to this order and its conditions.

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2. I acknowledge the validity of this order and the legal authority of the Board of Physician Quality Assurance to issue and enforce this order.
3. I acknowledge that by consent to this order, I am waiving my right to challenge in court the legal authority of the Board of Physician Quality Assurance to take action against my license/ability to practice as an unregistered health practitioner in the state of Maryland.

I, Glenn David Herman, M.D., have read this consent order and have carefully reviewed each and every part with my attorney, Gill Cochran, Esquire. I understand it and voluntarily agree to it.

I sign and consent to this order after having an opportunity to consult with counsel and with full understanding of the meaning and terms of the order.

GLENN DAVID HERMAN, M.D.
GILL COCHRAN, ESQUIRE
Counsel for Respondent

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**In the matter of
Bakul K. Pandya, M.D.
before the
Maryland Board of
Physician Quality Assurance
Final order**

Based on information received by the Board of Physician Quality Assurance of the State of Maryland (the board), the board charged Bakul K. Pandya, M.D., License Number D19625, Case Number 92-0006 (respondent), on July 23, 1991 under the Maryland Medical Practice Act (the act), *MD Health Occ. Code Ann. Section 14-404 et seq.*

The pertinent provisions of the act are as follows:

Section 14-404. Denials, reprimands, probations, suspensions, and revocations—Grounds.

(a) *In general.*—Subject to the hearing provisions of Section 14-405 of this subtitle, the board, on the affirmative vote of a majority of its full authorized membership, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:

- (21) Is disciplined by a licensing or disciplinary authority or convicted or disciplined by a court of any state or country or disciplined by any branch of the United States uniformed services or the Veterans' Administration for an act that would be grounds for disciplinary action under this section;

The ground underlying the charges of this section is that respondent

- (3) Is guilty of ... unprofessional conduct in the practice of medicine.

Based on clear and convincing evidence, the board, on the

affirmative vote of a majority of its full authorized membership considering this case, issues this final order.

Findings of fact

On November 27, 1991, a case resolution conference of the board (the conference) was held. Attending the conference were John F. Strahan, M.D., chief settlement officer; C. Frederick Ryland, assistant attorney general, counsel to the board; and Pamela J. LoPreato, compliance division. As a result of the conference, the respondent and the board agreed to enter into the following order, which includes findings of fact, conclusions of law, and a final order.

1. At all times relevant to these charges the respondent was and is licensed to practice medicine in the state of Maryland;
2. The Federation of State Medical Boards was informed by the Illinois Department of Professional Regulation that respondent had entered into a consent order and was reprimanded on December 16, 1988 for the following reason:

Information came to the attention of the Illinois board that respondent's license to practice medicine expired on July 31, 1987. Respondent practiced medicine without a license from the period July 31, 1987 to and until December 22, 1987. For this offense, he was formally reprimanded and a fine of \$1,400.00 was imposed.

3. On or before September 5, 1989, respondent submitted an application for renewal of his license to practice medicine in Maryland (1989 renewal application). Respondent answered incorrectly to the following question:

Has any state licensing or disciplinary board, or a comparable body in the armed services, denied your application for licensure, reinstatement or renewal; or taken any action against your license, including but not limited to reprimand, suspension, or revocation?

Respondent's answer was incorrect because

On December 16, 1988, respondent's license to practice medicine in Illinois was reprimanded.

Unaware of respondent's incorrect answers, the Maryland State Board of Physician Quality Assurance renewed respondent's license to practice medicine in Maryland effective October 1, 1989.

4. Practicing medicine without a license is unprofessional conduct in the practice of medicine.
5. A reprimand and fine by the Department of Professional Regulation of the State of Illinois is being disciplined by a licensing or disciplinary authority.
6. Incorrectly completing the 1989 renewal application could constitute fraudulently or deceptively obtaining or attempting to obtain a license, or unprofessional conduct in the practice of medicine.
7. Respondent was contrite and cooperative with the board

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in responding to these charges and in communicating with the case resolution conference on November 27, 1991.

Conclusions of law

Respondent committed the following prohibited acts:

1. Respondent was

Disciplined by a licensing or disciplinary authority or convicted or disciplined by a court of any state or country or disciplined by any branch of the United States uniformed services or the Veterans' Administration for an act that would be grounds for disciplinary action under this section; *MD Health Occ. Code Ann.* Section 14-404 (a) (21);

2. The underlying ground for this disciplinary action is that respondent

Is guilty of ... unprofessional conduct in the practice of medicine; *MD Health Occ. Code Ann.* Section 14-404 (a) (3) (1991).

Order

It is this 10th day of March 1992, by an affirmative vote of a majority of the full authorized membership of those members of the board who considered this case,

ORDERED, that respondent is REPRIMANDED and be it further

ORDERED, that this is a final order and as such will be considered a public document to *MD State Gov't Code Ann.* Section 10-611 *et seq.* (1989 Cum. Supp.).

ISRAEL H. WEINER, M.D., Chairperson
Maryland Board of Physician Quality Assurance

Consent

By this consent, I hereby admit to the findings of fact contained in this order. I hereby agree to be bound by the foregoing final order and its conditions and restrictions.

I am entering in this final order for the purpose of resolving the charges initiated by the Board of Physician Quality Assurance against my license to practice medicine as defined in the findings of fact and conclusions of law.

I acknowledged the validity of this order and the legal authority of the board of Physician Quality Assurance to issue and enforce this order.

I hereby waive any right to appeal this matter under §14-408 of the Health Occupations Article, *Annotated Code of Maryland*.

I understand that if I fail to abide by the conditions of this order, I may suffer disciplinary action against my license to practice medicine in the state of Maryland.

I sign and consent to this order after having an opportunity to consult with my counsel and with full understanding of the meaning and terms of the order.

BAKUL K. PANDYA, M.D.
ROBERT BARON, ESQUIRE

In the matter of
Willie E. Thompson, M.D.
before the
Maryland Board of
Physician Quality Assurance

Final order

Based on information received by the Board of Physician Quality Assurance of the State of Maryland (the board), the board charged Willie E. Thompson, M.D. (the respondent), License Number D34030, (DOB 3/27/47), under the Maryland Medical Practice Act (the act), *Md. Health Occ. Code* (HO) §14-404 (a)(1) and (21) (1991 Repl. Vol.).

The pertinent provisions of the act under HO §14-404 provide the following:

(a) Subject to the hearing provisions of §14-405 of this subtitle, the board, on the affirmative vote of a majority of its full authorized membership, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee

(1) Fraudulently or deceptively obtains or attempts to obtain a license for the applicant or for another; and

(2) Is disciplined by a licensing or disciplinary authority or convicted or disciplined by a court of any state or country or disciplined by any branch of the United States uniformed services or the Veterans' Administration for an act that would be grounds for disciplinary action under this section.

The grounds underlying the charges of this section are that the respondent

(b) ... is guilty of or convicted of or pleads guilty or *nolo contendere* with respect to a crime involving moral turpitude, whether or not any appeal or other proceeding is pending to have the conviction or plea set aside.

The board notified the respondent that he was entitled to a hearing on these charges and that the respondent could attend a case resolution conference regarding the charges.

On February 19, 1992, a case resolution conference of the board was held. Attending the conference were J. Andrew Sumner, M.D., chief case resolution officer; Christine J. Moore, Ira N. Brecher, M.D., and Harvey B. Kalin, M.D., board members; C. Frederick Ryland, board counsel; Steven P. Lemmey, assistant attorney general; Sylvia J. Anderson, paralegal; Willie E. Thompson, M.D., respondent; and Eric Rome, Esquire, counsel for Dr. Thompson. As a result of the conference, the respondent and the board agreed to enter into the following order.

Findings of fact

1. At all times relevant to these charges, the respondent was and is licensed to practice medicine in the state of Maryland.
2. The respondent was convicted in the Superior Court for the District of Columbia for the crime of soliciting for lewd and immoral purposes on July 11, 1987. The respondent's conviction for the crime of soliciting for lewd and

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immoral purposes is a conviction of a crime of moral turpitude under HO §14-404(b) "for any act that would be grounds for disciplinary action under the Maryland Medical Practice Act."

3. The respondent was disciplined by a disciplinary authority of another jurisdiction, the District of Columbia, Board of Medicine, on May 22, 1988. On May 22, 1988, the respondent entered into a consent order with the District of Columbia Board of Medicine which placed his medical license in the District of Columbia on probation for a period of two years. The District of Columbia order also reprimanded the respondent and required the respondent to fulfill certain conditions of probation.
4. On November 7, 1990, the respondent was the subject of an order of the District of Columbia Board of Medicine which stated that the respondent had successfully completed the two years of probation and placed his license in unrestricted status.
5. The respondent's conviction of the crime of "soliciting for lewd and immoral purposes" on July 11, 1987 is a conviction for a crime of moral turpitude under HO §14-404(b).
6. The consent order of May 27, 1988 between the respondent and the District of Columbia Board of Medicine, in which the respondent was reprimanded and placed on two years probation, is an order of discipline by a disciplinary authority of another jurisdiction, the District of Columbia.

Conclusions of law

The respondent committed the following prohibited acts:

1. The respondent was

disciplined by a licensing or disciplinary authority or convicted or disciplined by a court of any state or country or disciplined by any branch of the United States uniformed services or the Veterans' Administration for an act that would be grounds for disciplinary action under this section. *Md. Health Occ. Code Ann.* §14-404 (a) (21).

2. The respondent was

convicted of or pled guilty or *nolo contendere* with respect to a crime involving moral turpitude... *Md. Health Occ. Code Ann.* §14-404(b) (1991 Repl. Vol.).

Order

It is this 25th day of March 1992, by an affirmative vote by a majority of the full authorized membership of those members of the board who considered this case, ordered, that the respondent is REPRIMANDED; and be it further

ORDERED, that the allegation that the respondent violated §14-404(a) (1) did fraudulently or deceptively obtain or attempt to obtain a license for the applicant or licensee or for another is DISMISSED, and be it further

ORDERED, that this is a final order and as such will be considered a PUBLIC document pursuant to *Md. State Gov't Code Ann.* §10-611 *et seq.* (1989 Cum Supp.).

ISRAEL H. WEINER, M.D., Chairperson
Maryland Board of Physician Quality Assurance

Consent

By this consent I hereby admit to the findings of fact contained in this order. I hereby agree to be bound by the foregoing final order and its conditions and restrictions.

I am entering into this final order for purposes of resolving the charges initiated by the Board of Physician Quality Assurance against my license to practice medicine as defined in the findings of fact and conclusions of law.

I acknowledge the validity of this order and legal authority of the Board of Physician Quality Assurance to issue and enforce this order.

I hereby waive any right to appeal this matter under §14-408 of the Health Occ. Art. *Ann. Code of Maryland.*

I sign and consent to this order after having an opportunity to consult with my counsel, Eric Rome, Esquire and with full understanding of the meaning and terms of the order.

WILLIE E. THOMPSON, M.D.
ERIC ROME, ESQUIRE

■ ■ ■

**In the matter of
Irl Jesse Wentz, M.D.
before the
Maryland Board of
Physician Quality Assurance
Final order**

On June 11, 1991, the Board of Physician Quality Assurance (the board) charged Irl Jesse Wentz, M.D., License number D18562, Case number 91-0152 (respondent), under the Maryland Medical Practice Act (the act), *MD Health Occ. Code Ann.* Section 14-401 *et seq.*

The pertinent provisions of the act are as follows:

Section 14-404. Denials, reprimands, probations, suspensions and revocations—Grounds.

(a) *In general.*—Subject to the hearing provisions of Section 14-405 of this subtitle, the board, on the affirmative vote of a majority of its full authorized membership, may reprimand any licensee, place any licensee on probation, or suspend or revoke a license if the licensee:

- (21) Is disciplined by a licensing or disciplinary authority or convicted or disciplined by a court of any state or country or disciplined by any branch of the United States uniformed services or the Veterans' Administration for an act that would be grounds for disciplinary action under this section;

The grounds underlying the charges of this section are that respondent

- (3) Is guilty of immoral or unprofessional conduct in the practice of medicine.
- (22) Fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality

Board of Physician Quality Assurance Actions

medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this state.

On January 8, 1992, a telephone case resolution conference of the board (the conference) was held. Attending the conference were John F. Strahan, M.D., chief settlement officer; C. Frederick Ryland, assistant attorney general, counsel to the board; Pamela J. LoPreato, compliance staff; Geneva E. Goode, secretary; and by telephone, Otho L. Graham, Esquire and Irl Jesse Wentz, M.D. As a result of the conference, the respondent and the board agreed to enter into the following final order, which includes findings of fact, conclusions of law, and a final order.

Findings of fact

1. At all times relevant to these charges, the respondent was and is licensed to practice medicine in the state of Maryland;
2. Appropriate peer review includes the review of a physician's practice by a licensing or disciplinary authority of another jurisdiction.
3. On July 2, 1990, respondent entered into a consent order (the order) incorporated as Exhibit 1, with the Board of Medical Examiners of the State of North Carolina (the BMESNC) based upon its

... serious concerns regarding the prescribing practices of respondent with respect to controlled substances, it appearing that respondent's prescribing practices for controlled substances depart from or fail to conform to the standards of acceptable and prevailing medical practice in North Carolina (order, p.1).

4. In his consent order of July 2, 1990, respondent agreed to certain terms and conditions including, but not limited to, respondent's surrendering his DEA prescribing privileges and respondent's cooperation with the BMESNC in monitoring respondent's practice.
5. Respondent entered into a second consent order incorporated as Exhibit 2, with the BMESNC in which he accepted a reprimand for his prescribing the controlled substance, Lomotil, without restoration of his DEA prescribing privileges;
7. Respondent's failure to prescribe controlled substances within acceptable and prevailing medical practice is a failure to meet appropriate standards of peer review;
8. Respondent's failure to appropriately prescribe controlled substances is unprofessional conduct in the practice of medicine;
9. Respondent's restriction of his ability to prescribe controlled substances by the BMESNC is discipline by a licensing or disciplinary authority; and
10. Respondent's reprimand by the BMESNC is discipline by a licensing or disciplinary authority;
11. This action is a reciprocal discipline action based solely

- on physician activity in North Carolina for which respondent has already received discipline in his home state;
12. Respondent was contrite and cooperative with this board in his response to these charges and in his communication with the case resolution conference of January 8, 1992.

Conclusions of law

Respondent committed the following prohibited acts:

1. Respondent was

Disciplined by a licensing or disciplinary authority or convicted or disciplined by a court of any state or country or disciplined by any branch of the United States uniformed services or the Veterans' Administration for an act that would be grounds for disciplinary action under this section; *MD Health Occ. Code Ann. Section 14-404 (a) (21)*;

2. The underlying grounds for this disciplinary action were respondent's failure

To meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this state. *MD Health Occ. Code Ann. Section 14-404 (a) (22)*; and that respondent was Guilty of immoral or unprofessional conduct in the practice of medicine. *MD Health Occ. Code Ann. Section 14-404 (a) (3)*.

Order

It is this 17th day of March 1992, by an affirmative vote of a majority of the full authorized membership of those members of the board who considered this case,

ORDERED, that respondent is hereby REPRIMANDED; and be it further

ORDERED, that this is a final order and as such will be considered a public document pursuant to *MD State Gov't Code Ann. Section 10-611 et seq. (1989 Cum. Supp.)*.

ISRAEL H. WEINER, M.D., Chairperson
Maryland Board of Physician Quality Assurance

Consent

By this consent, I hereby admit to the findings of fact contained in this order. I hereby agree to be bound by the foregoing final order and its conditions and restrictions.

I am entering into this final order for the purpose of resolving the charges initiated by the Board of Physician Quality Assurance against my license to practice medicine as defined in the findings of fact and conclusions of law.

I acknowledge the validity of this order and the legal authority of the Board of Physician Quality Assurance to issue and enforce this order.

I hereby waive any right to appeal this matter under §14-408 of the Health Occupations Article, *Annotated Code of Maryland*.

I understand that if I fail to abide by the conditions of this

Board of Physician Quality Assurance Actions

order, I may suffer disciplinary action against my license to practice medicine in the state of Maryland.

I sign and consent to this order after having an opportunity to consult with my counsel and with full understanding of the meaning and terms of the order.

IRL JESSE WENTZ, M.D.
OTHO L. GRAHAM, ESQUIRE

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

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Indications: Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

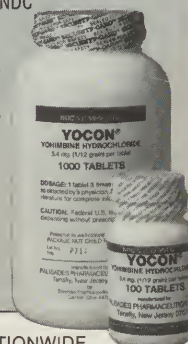
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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SELECTED COMMUNICABLE DISEASES IN MARYLAND IN 1991

JULY, 1992

This annual summary describes the epidemiology of selected communicable diseases in Maryland in 1991, reported by physicians, other health professionals, hospitals and local health departments. In addition, laboratories reported test results that showed evidence of communicable diseases that were not reported by a physician or hospital. Investigation of these cases added to the number of cases of amebiasis, gonococcal infection, *Haemophilus influenzae* disease, viral hepatitis, legionellosis, Lyme disease, meningococcal disease, atypical mycobacteriosis, salmonellosis, shigellosis and syphilis. Cases from death certificates listing communicable diseases as a cause of death were counted if confirmed by investigation.

In the following report, the number in parenthesis after the name of each disease indicates the number of reported cases in Maryland with onset of illness in 1991. Below the disease names are the incidence rates in Maryland and the United States, both based on the 1991 population projections. The cumulative number of cases reported to the Morbidity and Mortality Weekly Report (MMWR) system in 1991 (CDC. MMWR 1992, Vol. 40, Nos. 51 & 52) were used for the U.S. rates.

We appreciate the reporting of health care providers and laboratories, and the cooperation of the communicable diseases coordinators in the local health departments

and the infection control practitioners in the hospitals for reporting and investigating many of the cases.

CHOLERA (4)

0.08/100,000 (U.S. 0.01/100,000)

Cholera was reported in August (3 cases) in Montgomery and Howard counties, and in December (1 case) in Frederick County (Table 2). The age of the patients ranged from 28 to 36. All 4 were female; 3 were white and 1 was oriental.

The cases in August were caused by toxigenic *Vibrio cholerae* O1, biotype El Tor, serotype Ogawa. One of the cases required hospitalization. The patients had consumed a homemade sauce prepared from commercial frozen coconut milk imported from Thailand. Cultures of an unopened package of the same brand of coconut milk yielded toxigenic *V. cholerae* O1, El Tor, Ogawa and other pathogenic bacteria. The product was recalled.

A fourth patient contracted cholera while traveling in Brazil and Colombia. A stool culture was found to be positive for toxigenic *V. cholerae* O1, biotype El Tor, serotype Inaba.

Cholera was last reported in Maryland in 1988 (1), 1986 (1), and in 1984 (1).

ENCEPHALITIS, PRIMARY AND POSTINFECTIOUS (27)

0.6/100,000 (U.S. 0.4/100,000)

The incidence rate of 0.6 per 100,000 population in 1991 remained unchanged from 1990. The number of cases by county is shown in Table 1. The rate per 100,000 population in Montgomery County was 1.1, almost double the rate of the State. More than 40 percent of the patients had onset of illness in June and July. The ages ranged from 3 to 78 years (mean 36, median 29 years). More than 22 percent of the cases were less than 10 years of age, and a third were over 54 years of age. The male to female ratio was 0.9:1.0; the ratio of whites to nonwhites was 3.5:1.0.

Herpes viruses (7 cases, including 2 post-chickenpox) and Epstein-Barr virus (2) caused or were suspected to have caused 9 of the cases; the cause for the rest was not identified. Two patients died for a case fatality rate of 7.4 percent. No cases of arboviral encephalitis were reported in 1991. (The last case of eastern equine encephalitis reported in Maryland was in 1989.)

GONOCOCCAL INFECTIONS (21,646)

443.4/100,000 (U.S. 239.0/100,000)

Reported gonococcal infections decreased by 8 percent from the number in 1990 (21,446) (Figure 1). The cases by county are shown in Table 1. Baltimore City, with a two percent decrease from 1990, still had the highest rate per 100,000 population (1746.3) in the State followed by Dorchester (744.3), Wicomico (700.4), Prince George's (609.9), Worcester (356.1), Talbot (293.0), and Caroline (287.8) counties. Garrett (3.5) and Carroll (20.4) counties had the lowest rates. In 1990 the highest rates were noted in Baltimore City, Dorchester, Prince George's, Somerset, and Wicomico counties.

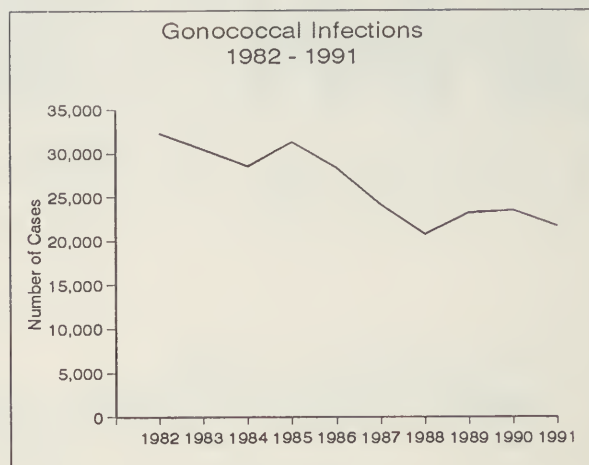


Figure 1.

The age distribution of the cases was similar to that in 1990 and 1989. Eighty-one percent of the cases were 15 to 34 years old. Rates per 100,000 population by age group and sex are shown in Figure 2. Among the 9,130 cases of gonorrhea for whom race was reported, 95 percent of the males and 89 percent of the females were black. Penicillinase-producing *Neisseria gonorrhoeae* (PPNG) accounted for 13 percent of the total reported gonorrhea, a slight increase from 12.7 percent in 1990.

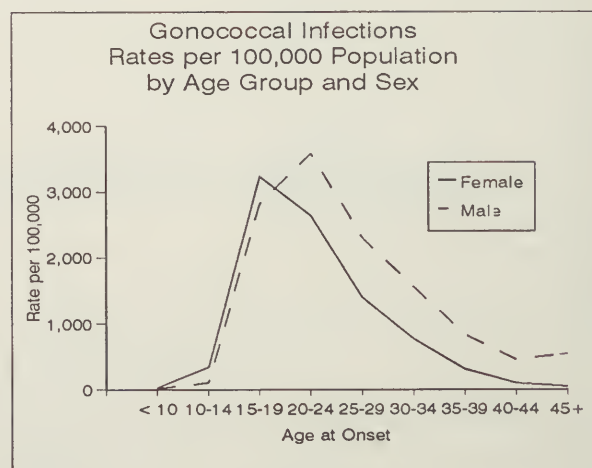



Figure 2.

Table 1. Reported Cases of Notifiable Diseases in Maryland by County, 1991

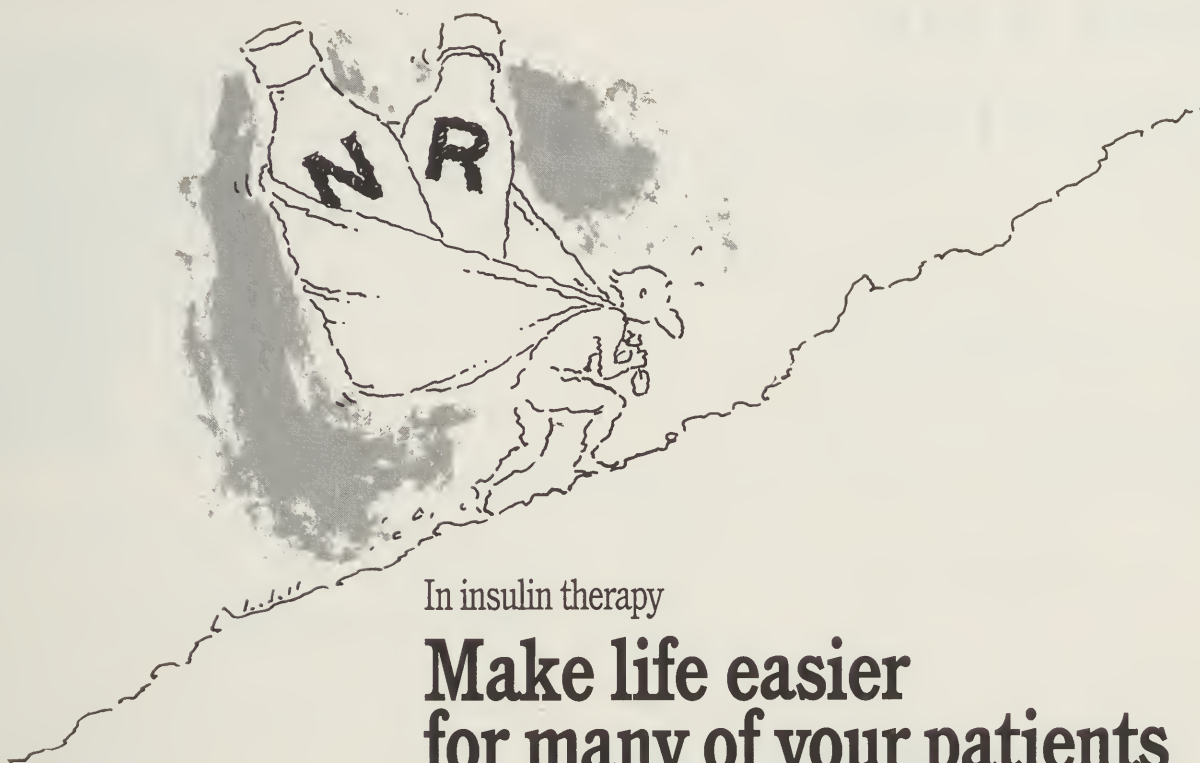
	Inf. Parotitis (Mumps)	Pertussis	Rubella (German Measles)	Rubeola (Measles)	Viral Hepatitis				Encephalitis	Haemophilus influenzae Disease	Meningococcal Disease	Meningitis, Viral	Salmonellosis	Typhoid Fever	Shigellosis	AIDS	Gonorrhea	Syphilis, Primary and Secondary	Syphilis, Congenital	Tuberculosis	Lyme Disease	Rocky Mountain Spotted Fever	Animal Bites	Rabies, Animal
					Unsp.		NA/NB																	
					A	B	NA	NB																
Population																								
Maryland	4,791,514																							
Allegany	75,386	1	-	-	2	4	-	-	1	-	-	4	11	-	-	2	32	-	-	1	1	-	291	15
Anne Arundel	431,232	19	3	16	22	18	2	-	2	4	5	23	98	1	5	27	778	63	1	15	22	3	1301	57
Baltimore City	740,170	47	4	12	93	134	9	1	1	13	7	33	252	1	112	382	12807	210	9	147	10	2	1401	2
Baltimore Co.	699,934	58	3	11	40	49	-	4	4	4	6	61	168	-	26	57	676	20	1	42	49	4	644	27
Calvert	53,073	5	-	5	1	2	-	2	2	1	-	6	15	-	-	1	77	2	-	2	4	-	169	10
Caroline	27,447	-	3	1	2	4	1	-	1	-	-	4	10	-	2	2	80	1	-	1	22	1	86	66
Carroll	127,465	4	3	5	5	12	-	-	2	1	1	6	42	-	-	3	26	-	-	5	4	1	266	18
Cecil	79,818	1	4	68	2	5	2	-	-	2	2	13	12	-	-	1	78	-	-	-	30	1	307	18
Charles	103,279	4	-	5	-	3	-	1	1	2	1	4	18	-	2	7	208	32	2	3	10	3	346	5
Dorchester	30,726	1	1	-	1	3	-	-	-	-	-	5	34	-	1	6	227	8	-	-	5	-	95	-
Frederick	154,228	2	2	7	1	1	-	1	-	5	-	5	24	1	1	10	140	2	-	3	2	-	443	68
Garrett	28,381	15	-	5	-	1	-	-	-	1	-	-	5	-	-	-	1	-	-	-	-	-	96	26
Harford	183,149	3	1	21	6	18	4	1	1	-	-	9	39	-	3	11	141	4	-	4	18	-	471	18
Howard	187,158	2	4	-	11	8	1	-	-	-	-	8	45	1	8	11	97	5	-	6	7	1	325	10
Kent	17,174	-	-	-	-	4	-	-	-	1	1	7	6	-	-	-	16	2	-	-	12	-	36	20
Montgomery	732,380	14	6	11	35	32	3	8	8	6	5	38	200	-	40	92	634	48	1	94	11	2	1357	31
Prince George's	724,122	67	9	8	28	70	1	1	1	2	4	59	137	4	51	165	4530	453	37	84	8	1	1176	22
Queen Anne's	33,931	-	-	-	1	2	1	-	-	-	-	6	9	-	5	2	37	-	-	2	27	-	162	77
Saint Mary's	74,785	3	1	1	2	1	1	-	-	-	2	15	26	-	1	2	162	6	1	6	14	4	176	5
Somerset	22,895	-	-	-	2	-	1	1	1	-	-	1	8	-	-	1	84	9	-	1	2	-	56	-
Talbot	29,287	2	-	-	3	2	-	-	-	-	-	2	16	-	1	2	92	2	-	1	4	-	111	54
Washington	120,907	1	1	3	1	4	2	-	2	-	1	19	29	-	-	10	65	9	-	4	-	-	167	30
Wicomico	75,671	2	1	-	-	9	4	1	-	1	-	4	33	-	-	14	533	131	2	25	6	-	332	-
Worcester	38,916	-	-	-	-	1	1	-	-	-	-	1	25	-	-	4	125	9	-	5	15	-	113	-

*Includes 29 cases in prisons.

Table 2. Other Reportable Diseases in Maryland with Onset in 1991

Disease	Total	Jurisdiction of Residence of Cases
Amebiasis	9	AA-2, B.City-1, Carr-1, Mont-3, PG-2
Campylo- bacteriosis	119	AA-15, B.City-35, Bal-3, Cal-1, Carr-12, Cec-1, Ch-1, Fr-3, Har-2, How-9, Kent-1, Mont-7, PG-10, QA-2, Som-2, Wash-1, Wic-7, Wor-7
Cholera	4	Fr-1, How-1, Mont-2
Giardiasis	90	Al-1, AA-24, B.City-10, Bal-6, Cal-2, Caro-1, Carr-4, Cec-5, Fr-1, Gar-2, Har-3, How-6, Mont-2, PG-11, StM-6, Wash-1, Wic-1, Wor-4
Hepatitis E	1	AA-1
Kawasaki syndrome	17	B.City-1, Bal-1, Mont-7, PG-6, Wash-1, Wor-1
Legionellosis	34	Al-1, AA-3, B.City-4, Bal-3, Caro-1, Cec-1, Dor-1, Fr-4, Kent-1, Mont-4, PG-4, QA-1, Wash-5, Wic-1
Leprosy	5	Bal -1, How-2, Mont-2
Listeriosis	6	B.City-3, Mont-1, PG-2
Malaria	62	AA-3, B.City-7, Bal-6, Ch-1, Fr-1, How-1, Mont-16, PG-27
Meningitis bacterial*	166	AA-8, B.City-55, Bal-24, Cal-2, Caro-1, Carr-6, Cec-1, Ch-3, Dor-2, Fr-3, Gar-1, Har-6, How-4, Kent-2, Mont-9, PG-23, QA-1, StM-3, Som-1, Tal-1, Wash-4, Wic-5, Wor-1
fungal	39	AA-1, B.City-23, Bal-2, Ch-2, Dor-1, Gar-1, Har-2, Mont-2, PG-5
unspecified	28	B.City-9, Bal-2, Carr-1, Ch-2, Fr-1, Har-1, Mont-1, PG-6, QA-1, StM-1, Wash-3
Mycobacteriosis nontuberculous	507	Al-2, AA-33, B.City-174, Bal-30, Cal-1, Caro-1, Carr-3, Ch-3, Fr-10, Har-6, How-10, Mont-85, PG-101, QA-1, StM-1, Som-4, Tal-4, Wash-1, Wic-25, Wor-12
Newborn infection	84	AA-2, B.City-8, Bal-29, Cec-2, Fr-1, Har-12, How-1, Mont-11, PG-16, Wic-1, Wor-1
Poliomyelitis	1	AA-1
Psittacosis	5	B.City-2, Mont-2, StM-1
S.typhi carrier	2	Mont-2
Tetanus	1	B.City-1
Tularemia	2	Bal-1, QA-1
Vibrio (non-01) infection	2	Fr-1, PG-1
Yersiniosis	28	AA-5, B.City-17, Carr-1, Cec-3, Mont-2

* Other than *H. influenzae* and *N. meningitidis*

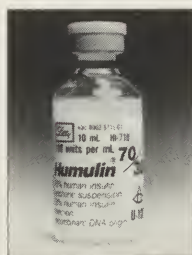


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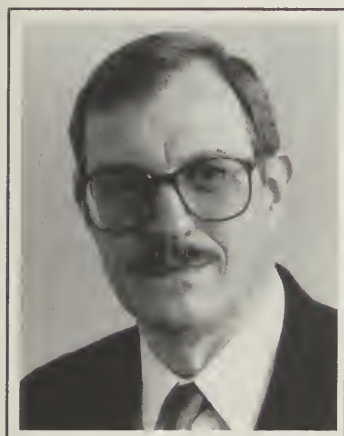
Test Your Knowledge,

a quiz conducted by the *Maryland Medical Journal* during Med Chi's 1992 Annual Meeting, asked physicians to match ten quotations on health and the practice of medicine with their author or speaker.

The *MMJ* would like to thank all those who participated in this difficult academic challenge and to congratulate the four individuals with the most correct answers:

- *Benjamin Rothfeld, M.D., Harford County*
- *Joseph F. LiPira, M.D., Baltimore County*
- *Henry J. Farkas, M.D., Cecil County*
- *Gerald A. Hofkin, M.D., Baltimore City*

1. A desire to take medicine is, perhaps, the great feature which distinguishes man from other animals. *William Osler*
2. If your stomach disputes you, lie down *Satchell Paige*
and pacify it with cooling thoughts.
3. Gentlemen, this is no humbug. *John C. Warren*
4. Psychoanalysis is confession without absolution. *G.K. Chesterton*
5. PHYSICIAN, n. One upon whom we set our *Ambrose Bierce*
hopes when ill and our dogs when well.
6. You must also avoid adopting, in order to gain a patient, *Hippocrates*
luxurious headgear and elaborate perfume. For excess of strangeness
will win you ill repute, but a little will be considered in good taste.
7. *When I was sick and lay a-bed,* *Robert Louis*
I had two pillows at my head, *Stevenson*
And all my toys beside me lay
To keep me happy all the day.
8. The only weapon with which the unconscious patient can im- *W.S. Halstead*
mediately retaliate upon the incompetent surgeon is hemorrhage.
9. A physician is judged by the three A's: *Paul Reznikoff*
Ability, Availability and Affability.
10. Early to rise and early to bed makes *James Thurber*
a male healthy and wealthy and dead.



John Chapman Urbaitis, M.D. has recently been appointed psychiatrist-in-chief at Sinai Hospital where he has served as associate chief since 1977 and where he helped to establish the department as a major community mental health center. During his tenure at Sinai Hospital, he developed outpatient and outreach services for adults and youngsters including community rehabilitation

and residential programs, treatment for patients who are mentally ill and substance abusers, expanded emergency services, and primary medical care programs for drug-dependent patients. He also designed a curriculum in community psychiatry for residents from the University of Maryland.

Dr. Urbaitis was president of the Maryland Psychiatric Society from 1988 to 1989 and has been a Maryland representative to the American Psychiatric Association's (APA) Assembly since 1983. He helped found the Maryland Council of Community Mental Health Centers and was a major force in gaining the APA's approval of guidelines for psychiatrists in community mental health centers.

An assistant professor of psychiatry at Johns Hopkins University and clinical assistant professor of psychiatry at the University of Maryland, Dr. Urbaitis was named mental health professional of the year by the Baltimore Mental Health Association in 1989.

He received his medical degree from Cornell University Medical College in 1966, and after an internship in medicine in Brooklyn, New York, served his residency in psychiatry at the Phipps Clinic of Johns Hopkins Hospital. ■



Molecular Foundations of Oncology. Samuel Broder, M.D. (editor). Baltimore, MD: Williams & Wilkins. 1991. 526 pages. \$110.00

It has long been obvious that the success of the war on cancer depends on our ability to determine the genetic basis of the disease, and then use this information to create effective diagnostic, therapeutic, and possibly preventive techniques. What used to be a dream is rapidly becoming a reality. The explosion in knowledge over the past decade is remarkable. We now find ourselves on the threshold of dramatic advances which, until recently, were only dreamed of.

Dr. Broder has been at the forefront of his field. He has assembled a group of authors who are authorities in molecular biology. More importantly, the contributors are not limited to bench scientists, but include clinicians with the foresight and ability to translate laboratory techniques into investigative therapies for patients. Perhaps present successes appear few, far between, and very expensive. However, we have only taken but a small step in a long journey.

This is a very complicated topic and the book reflects that complexity. Several major areas are discussed including cytogenetics and molecular pathology, the application of molecular techniques to diagnosis and therapy, oncogenes and retroviruses, the clinical applications of molecular biology, the role of growth factors, and, finally, an evaluation of concepts for diagnosis and therapy of cancer.

From a technical perspective, the book is complicated. It is detailed, requiring intense concentration, particularly for those of us who have only limited background in the field of molecular biology. It is not a text for simple reference, but requires effort on the part of the reader. However, having made that effort, the reader will learn about the topic and have a reasonably clear understanding of this field. Numerous illustrations, charts, and graphs enhance the text. The references are numerous, and there is an extensive index.

The text is not uniform in presentation. Some of the chapters are written in first person and others are actually "chatty." This is a departure from the usual dry nature of most textbooks.

Make no mistake: This book is a difficult read. It is a useful reference for oncologists and molecular biologists. The practicing physician may find it of interest, but will have to read diligently to understand the complicated material. However, this is the face of the future and represents an area of science that will likely produce extensive progress in the near term. This book is an excellent reference to understand what has been accomplished and where we are headed.

J. LEONARD LICHTENFELD, M.D., F.A.C.P.
Baltimore ■

The Johns Hopkins Medical Institutions

All courses at the Turner Auditorium unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Education, 720 Rutland Ave., Baltimore, MD 21205 (410-955-2959).

- Control of biohazards in the research laboratory.** Info: Dr. Jacqueline Corn, 410-955-2609. **July 13–17**
- Endoscopic sinus surgery: Hands-on laboratory and lecture.** 19 Cat 1 AMA/PRA credits for lab and lectures. 14.5 Cat 1 AMA/PRA credits for lectures only. Fee: \$1,250 lab and lecture; \$295 lectures only. **Aug. 13–15**
- Laryngeal disorders: Hands-on colloquium, laboratory and workshops.** Cat 1 AMA/PRA credits pending. Fee: \$1,000 colloquium and lab; \$400 colloquium for physicians; \$225 colloquium for residents and allied health professionals. **Sept. 10–12**
- Annual update on obstetric anesthesia,** at Stouffer Harborplace Hotel, Baltimore, MD. 8 Cat 1 AMA/PRA credits. Fee: \$150 physicians; \$25 residents and fellows. **Sept. 12**
- Pediatrics for the practitioner—Update 1992.** Cat 1 AMA/PRA credits available. Fee: TBA. **Sept. 17–18**
- 21st annual diagnostic ultrasound in gynecology and obstetrics and abdomen,** at the Stouffer Harborplace Hotel, Baltimore, MD. 16.5 Cat 1 AMA/PRA credits. Fee: 3 days, physicians \$400, others \$300; 2 days, physicians \$300, others \$225; 1 day, physicians \$150, others \$125. **Sept. 25–27**
- 34th annual Emil Novak Memorial Course: Gynecology, gynecological pathology, endocrinology, and high-risk obstetrics.** 53 Cat 1 AMA/PRA credits; 51 ACOG cognates. Fee: \$675 physicians; \$475 residents, fellows, and allied health professionals. **Oct. 12–17**
- Diabetic retinopathy.** 8 Cat 1 AMA/PRA credits. Fee: \$200 physicians; \$100 residents, fellows, and allied health professionals. **Oct. 23**
- Update on sinusitis for the practitioner.** 9 Cat 1 AMA/PRA credits. Fee: \$175 physicians; \$95 residents, fellows, and allied health professionals. **Oct. 30**
- Hemodynamic monitoring, patient care, and pulmonary artery catheterization—A hands-on course.** 14 Cat 1 AMA/PRA credits. Fee: \$575. **Oct. 31–Nov. 1**

Continuously throughout the year

- Visiting preceptorship in pediatric critical care medicine.** Ongoing five-day preceptorship by appointment. 40 Cat 1 AMA/PRA credits. Fee: \$600.
- Ophthalmic electrophysiology technician training course.** Ongoing one-week course by appointment. The Wilmer Eye Institute, Baltimore, MD.
- Ophthalmology grand rounds.** Audiovisual continuing education series of case discussions for clinicians; 3–8 topics per conference. Thursdays, 7:30–9:00 a.m. 2 Cat 1 AMA/PRA credits per session. Info: 410-955-5700.
- Neuro-ophthalmology conference.** Held twice per month. Info: 410-955-5700.
- Cornea conference.** Held monthly. Info: 410-955-5700.
- The department of radiology and radiological sciences** offers several courses in abdominal and obstetrical ultrasound. Info: P. Williams, 410-955-3169.
- Visiting physicians.** Offered throughout the year for experience in the lab and participation in read-in sessions; by appointment only. 40 Cat 1 AMA/PRA credits. Fee: \$500.
- Johns Hopkins medical grand rounds.** Accredited audiovisual continuing education series of case discussions for clinicians; thirty topics per year in five bimonthly programs. Individual and group subscriptions. 40 Cat 1 AMA/PRA credits. Info: 410-955-3988.
- Microsurgery training at the Johns Hopkins Hospital.** One-week program offered continuously throughout the year. 40 Cat 1 AMA/PRA credits. Info: P. Williams, 410-955-3169.

University of Maryland

For each course, additional information may be obtained by contacting the Program of Continuing Education, University of Maryland School of Medicine, Room 14-011, BRB, 655 W. Baltimore St., Baltimore, MD 21201 (410-328-3956) or by calling the phone number listed after a specific program. FAX 410-328-3103.

- Topics in pulmonary medicine**, at the Baltimore Marriott Inner Harbor Hotel, Baltimore, MD. 8 Cat 1 AMA/PRA credits. Fee: Before August 8, \$150 physicians, \$100 allied health professionals, interns, residents, and fellows; After August 8, \$175 physicians, \$125 allied health professionals, interns, residents, and fellows. Info: Larry R. Saunder, 410-328-4497. **Sept. 12-13**
- HIV Coordinator Skills Course**, sponsored by the Maryland AIDS Professional Education Center, in Salisbury, MD. Info: Gwen Kergides, 410-328-8639. **Sept. 24-25**
- HIV Counseling skills I**, sponsored by the Maryland AIDS Professional Education Center, in Annapolis, MD. Info: Gwen Kergides, 410-328-8639. **Oct. 19-22**
- AIDS: A challenge to primary care—4th annual conference**, sponsored by the Maryland AIDS Professional Education Center, in Baltimore, MD. Info: Gwen Kergides, 410-328-8639. **Oct. 26-27**

Continuously throughout the year

- Visiting professor program.** A 1992 directory of speakers and their topics is available to area hospitals and other health care organizations. NO administrative fees are charged for this service. Info: 410-328-3956.
- Departmental rounds and conferences.** Weekly, hands-on, and lecture presentations hosted by the University's clinical departments. Hour-for-hour Cat 1 AMA/PRA credits available. Brochure available.
- Pediatric grand rounds.** Every Thursday from September to June, except third Thursday, in the R. Adams Cowley Shock Trauma Auditorium. Info: Bonnie Winters, 410-328-6777.

Physician Placement Services

The Medical and Chirurgical Faculty of Maryland maintains a Placement Service for the convenience of Maryland physicians, hospitals, and communities in search of candidates for positions available in our state. A detailed description of such opportunities should be forwarded to:

Physician Placement Service
1211 Cathedral St., Baltimore, MD 21201-5585
(301-539-0872)

Physicians wishing to locate in Maryland are invited to submit a resume to be kept on file with the Physician Placement Service. Candidates are requested to inform the Faculty when they are no longer available for consideration for opportunities in Maryland.

MMJ announcements on the Classified Advertising page for Physician Placement Service are charged at the regular Classified Advertising rate.

Miscellaneous meetings

- | | |
|--|--------------------|
| A focused seminar on peripheral pain , sponsored by the Washington Adventist Hospital, at the Hyatt Regency Bethesda, Bethesda, MD. Info: Robert Gerwin, M.D., 301-982-7944. | July 17-19 |
| Initial thoughts on the city and state: Dean Donald Wilson, M.D. , sponsored by the Baltimore City Medical Society, at St. Agnes Hospital. 1 Cat 1 AMA/PRA credit; 1 AAFP prescribed hour. Fee: none. Info: Lorraine Wallace, 410-625-0022. | Sept. 3 |
| Maryland Chapter of the American College of Surgeons annual fall meeting , at the Harbor Court Hotel, Baltimore, MD. 3 Cat 1 AMA/PRA credits. Fee: none. Info: Dr. Frederick Walker, 410-836-0909. | Sept. 19 |
| 4th annual trauma conference , sponsored by the Peninsula Regional Medical Center, at the Sheraton Ocean City Resort and Conference Center, Ocean City, MD. Cat 1 AMA/PRA credits available. Fee: \$200. Info: Darlene Kwiatkowski, 410-543-7328. | Sept. 24-25 |
| Traditional Chinese medicine , sponsored by the Baltimore City Medical Society, at Harbor Hospital Center. 1 Cat 1 AMA/PRA credit; 1 AAFP prescribed hour. Fee: none. Info: Lorraine Wallace, 410-625-0022. | Oct. 1 |
| Sixth annual national disability management conference and exhibit , sponsored by the Washington Business Group on Health (WBGH), at the Crystal Gateway Marriott, Arlington, VA. Fee: \$400 WBGH members; \$475 nonmembers. Info: 202-408-9320. | Oct. 26-27 |

Continuously throughout the year

- Fluorescein angiography conference**, sponsored by the Retina Center at St. Joseph Hospital, first and third Mondays of each month; 8:00-9:00 a.m. Fee: none. Info: R. Classon, 410-337-4500.

Shady Grove Adventist Hospital,

9901 Medical Center Drive, Rockville, MD. Info: 301-279-6115.

- | | |
|--|-----------------|
| Pain control in the cancer patient. | July 2 |
| Pediatric cancer. | July 9 |
| Rheumatology. | July 16 |
| Depression: Treatment in the office setting and comparison of newer and older agents. | July 23 |
| Current concepts in plastic surgery. | July 30 |
| Risk management. | Aug. 13 |
| New developments in the treatment of asthma. | Aug. 20 |
| The noninvasive peripheral vascular lab. | Sept. 10 |



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Available immediately. BC/BE pediatrician to join Mercy Medical Center's pediatric program with the University of Maryland. Appointment and teaching responsibilities. Call 410-332-9594 or send CV to R. Gutberlet, M.D., Chairman, Pediatrics, Mercy Medical Center, 301 St. Paul Place, Baltimore, MD 21202. We are an equal opportunity employer.

INTERNIST

Two Board Certified Internists seek Board Certified/Eligible Associate for growing practice on Maryland's Eastern Shore. Competitive salary, excellent benefits. Relaxed urban/rural area. Send CV or contact: Salisbury Med-Center, 1104 Healthway Drive, Salisbury, Maryland 21801 (410-543-8900), Attn: William Robins, M.D.

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Part-time for booming family medical practice. Prefer emergency physicians with board certification in internal medicine, family practice, or emergency medicine. Part-time to start building into first time practice. Great risk-free opportunity. For further information, please call 410-721-6500.

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Growing group practice affiliated with the largest HMO in Maryland seeks additional BC/BE physicians in Internal Medicine, Family Practice and Pediatrics. Positions available in Baltimore and surrounding metropolitan areas. Reply with C.V. to Daniel J. Winn, M.D., P.O. Box 13126, Baltimore, MD 21203-3126.

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Well-established solo practice. Dr. is moving. Need to sell. Bowie, MD. Contact: Charles Attillisi, 703-705-1753.

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Sinai Hospital of Baltimore is now hiring part-time Pediatric Preceptors to work in the Emergency Room. For more information, please call Susan Moriarty, M.D. at 410-578-5737.

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Please submit copy seven weeks prior to the first day of the month in which you wish the ad to run. Items must be related to the practice of medicine. Ads placed for the benefit of a hospital or an HMO will be billed at the nonmember rate. Spouses of deceased members shall be entitled to two complimentary insertions for the disposal of the deceased physician's practice or equipment. Ad cancellations must be received in writing seven weeks prior to the first of the month.

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Are you concerned about the effects of family violence and victimization within your community?

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Violence among family members has reached staggering proportions. Every year more than 2 million cases of child abuse and neglect are reported, between 2 and 4 million women are battered by their spouses, and between 700,000 and 1.1 million of the elderly population are abused.

The American Medical Association has formed a *National Coalition of Physicians Against Family Violence*. Through the *Coalition* the American Medical Association hopes to involve you in activities that address issues of child abuse, sexual assault, domestic violence and elder abuse because you have the unique ability to identify the symptoms, first-hand. By joining the *National Coalition* you will be showing your concern about the effects of family violence and victimization, and will become a committed advocate within your community for the prevention of family violence.

Through the *Coalition* you will:

- be informed about local contacts and referrals
- become aware of local and regional resources
- be provided with information regarding model educational programs
- become aware of treatment guidelines and protocols.
- have access to newsletters, public education materials and other publications
- receive an official membership card and frameable poster alerting your patients of your interest in and concern for this problem.

The only **cost** to you is **your commitment** to help curb this problem. Simply complete the membership application form below and mail to the Department of Mental Health, American Medical Association, 515 N. State Street, Chicago, IL 60610.

Yes, include my name in the *Coalition's* membership

Name _____

Address _____

City/State/Zip _____ Telephone # _____

Specialty _____

Auxiliary Member ☐ Yes ☐ No Other _____

Area of interest within Family Violence: ☐ Child Abuse ☐ Sexual Assault ☐ Domestic Violence
☐ Elder Abuse ☐ Other

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† Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

‡ Verapamil should be administered cautiously to patients with impaired renal function.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully

monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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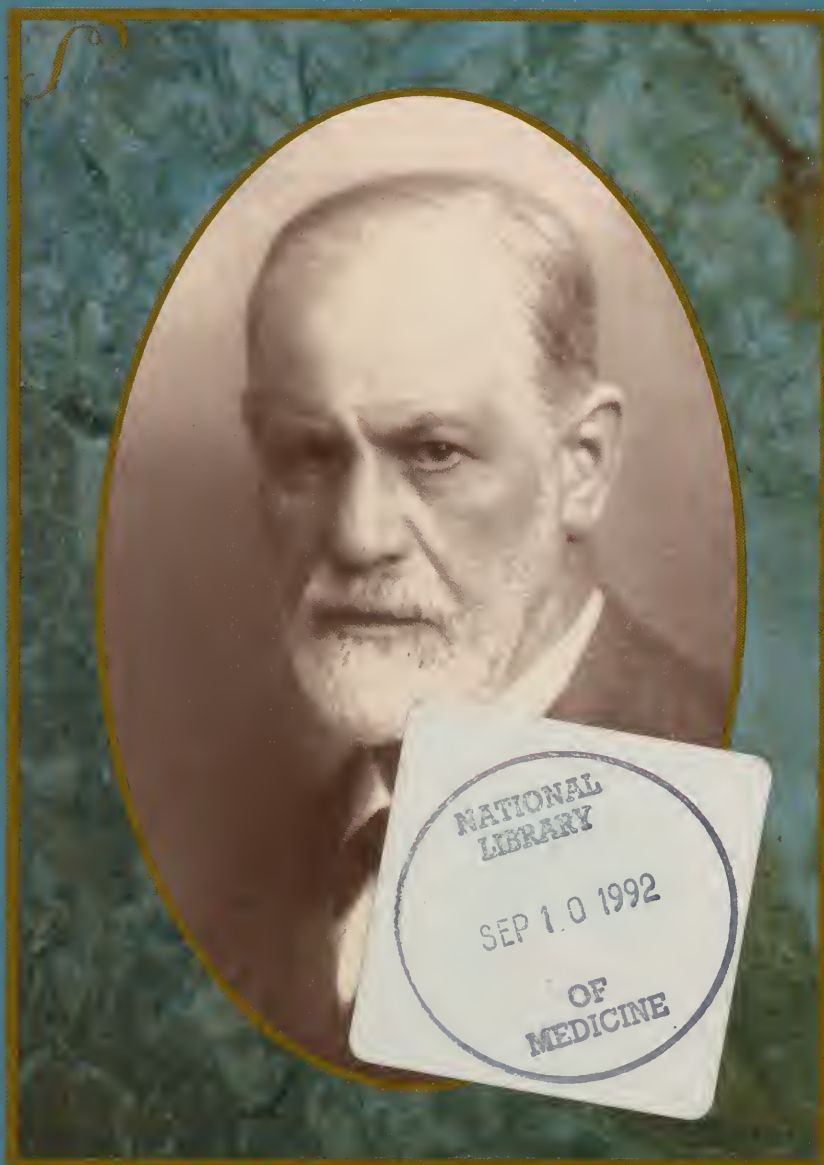
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1992 Semiannual Meeting

Friday, Saturday,
Sunday
September, 18, 19, 20, 1992

at the
Princess Royale Hotel

Oceanfront at 91st Street
in
Ocean City, Maryland

Preliminary Program



Registration Form

1992 Med Chi Semiannual Meeting

Friday—Sunday, September 18–20, 1992 ❖ Princess Royale Hotel, Ocean City, Maryland

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Physicians are encouraged to send this registration form by Friday, September 11, 1992 to

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Friday, September 18, 1992

11:00 a.m.—5:00 p.m.—Registration

12:30 p.m.—1:30 p.m.—Visit the exhibits

1:30 p.m.—3:00 p.m.—Council Meeting

Welcome

Joseph Fastow, M.D., Chairperson

Opening Remarks

Joseph T. Painter, M.D., President-elect,
American Medical Association

3:00 p.m.—4:00 p.m.—Break—Visit the Exhibits

4:00 p.m.—6:00 p.m.

"Substance Abuse Education for Primary Care Physicians"

Introducer:

Carmine M. Valente, Ph.D., Deputy Executive Director, Med Chi

Speaker:

Kevin S. Ferentz, M.D., Assistant Professor of Family
Medicine, University of Maryland; Director, Student and
Employee Health

Objectives: Participating physicians will be able to

- understand the positive and effective role primary care physicians have in treating substance abusing patients,
- recognize and understand how to use several uncomplicated substance abuse screening questionnaires and laboratory tests for the assessment of alcohol and drug problems, and
- describe some techniques and strategies for counseling patients with substance abuse problems.

Target Audience: Primary care physicians

CME Credit: 2.0

4:00 p.m.—6:00 p.m.

*"Recent Breakthroughs in Understanding and
Reducing Physician Stress"*

This two-hour workshop will introduce new insights and coping strategies for reducing physician stress.

Introducer:

J. Richard Lilly, M.D., Chairperson, Committee on
Scientific Activity

Speaker:

Morton C. Orman, M.D., Practicing Internist and Author

Objectives: Participating physicians will

- recognize three very common—but inaccurate—beliefs about stress;
- understand why physical exercise, meditation and other relaxation techniques are *not* the best strategies for relieving physician stress; and

Support our Exhibitors

Exhibits are an integral part of Med Chi's semiannual meeting and are a valuable adjunct to the scientific program.

During this year's semiannual meeting, Med Chi has allocated several special time periods for physicians to meet one-on-one with exhibitors. By visiting the exhibits, you will help ensure that Med Chi continues to receive valuable income that allows us to offer you annual and semiannual meetings.

Med Chi urges you to express your appreciation to exhibitors by visiting their booths and discussing your mutual involvement in patient care.

Exhibits will be open:

Friday, September 18

12:30 p.m.–1:30 p.m.

2:30 p.m.–4:30 p.m.

Saturday September 19

9:30 a.m.–11:30 a.m.

2:30 p.m.–4:30 p.m.



Friday, Sept. 18 (contd.)

- learn about a new and effective coping method for dealing with anger, frustration, worry, guilt and other "hassles" of professional life.

Target Audience: All physicians

CME Credit: 2.0

Saturday, September 19, 1992

7:30 a.m.–5:00 p.m.—Registration

8:00 a.m.–9:30 a.m.

"Medical Management in Home Care"

Introducer:

Joanne G. Schwartzberg, M.D., Director, Department of Geriatric Health, American Medical Association

Speakers:

George Taler, M.D., Assistant Professor, Department of Family Medicine, University of Maryland; Chairperson, Long-Term Care and Geriatrics Committee, Med Chi

Joseph Zebley, M.D., Past President, Maryland Academy of Family Physicians; Clinical Instructor, Department of Family Medicine, University of Maryland

Frances Lodder, L.C.S.W., Social Worker, Division of Geriatric Medicine, Francis Scott Key Medical Center

Carol C. Sylvester, M.S., C.R.N.P., Director, Johns Hopkins Home Care, The Johns Hopkins Health System

Objectives: Participating physicians will be able to

- identify the needs of the home-bound elderly,
- identify community resources for the elderly, and
- practice appropriate medical management of the elderly at home.

Target Audience: Family physicians, internists, and primary care physicians

CME Credit: 1.5

8:00 a.m.–10:00 a.m.

"Claims Abstracts: Learning from Experience"

Sponsored by the Medical Mutual Liability Insurance Society of Maryland

Introducer:

Raymond M. Yow, M.D., Chairperson of the Board and CEO, Medical Mutual Liability Insurance Society of Maryland

Speakers:

Thomas G. Chiccone, M.D., F.A.C.E.P., Capital Emergency Associates

Lori Mayers, Claims Representative, Medical Mutual Liability Insurance Society of Maryland



Keynote Speaker

Joseph T. Painter, M.D.
President-elect
American Medical Association

Dr. Painter, vice president for health policy and a professor of medicine at the University of Texas, M.D. Anderson Cancer Center, was elected president-elect of the American Medical Association (AMA) on June 21, 1992. He had served as chair of the Board of Trustees since June 1992, was vice-chair in 1989, and has been a member of the Board since 1984. He has been a member of the Executive Committee since 1985 and the Finance Committee since 1984. Dr. Painter has been an AMA Commissioner to the Joint Commission on Accreditation and Healthcare Organizations and served as chair of the AMA Commissioners. He is a USA delegate to the World Medical Association and is chair of the Council on Ethics and Judicial Affairs of that organization.

Born in Austin, Texas, Dr. Painter received his MD degree from the University of Texas Medical Branch at Galveston in 1949, after which he served his internship and residency in internal medicine at the Hospital of the University of Pennsylvania. He is a diplomate of the American Board of Internal Medicine and a fellow of the American College of physicians.



Saturday, Sept. 19 (contd.)

Objectives: Participating physicians will

- develop an understanding of a medical malpractice claim,
- be able to identify and discuss pertinent malpractice issues,
- learn strategies to enhance awareness of loss prevention skills, and
- reinforce their knowledge of current diagnostic and therapeutic modalities.

Target Audience: All physicians

CME Credit: 2.0

The program is open to all physicians. Med Mutual will give a five percent premium discount on 1993 medical professional liability renewal policies to their members who attend. A \$40 program fee is required for physicians to obtain the discount.

9:30 a.m.—10:30 a.m.—Break—Visit the exhibits

10:30 a.m.—12:30 p.m.—Plenary Session

"Forum on Health Care Reform"

A panel discussion of major health reform issues, focusing on special needs in Maryland. Topics include a review of state initiatives throughout the country and specific reform issues such as universal access to health care, basic health insurance benefits, insurance portability, pre-existing health conditions, reduction of the "hassle factor," and Health Access America.

1:30 p.m.—3:30 p.m.—House of Delegates Meeting

Introductory Remarks

Jose M. Yosunico, M.D., President

Keynote Address

Joseph T. Painter, M.D., President-elect,
American Medical Association

3:30 p.m.—4:30 p.m.—Break—Visit the exhibits

4:30 p.m.—6:00 p.m.

"Sexual Harassment and Personnel-Related Issues in the Physician's Office"

Introducer:

Jose Martinez, M.D., Member, Committee on
Scientific Activity

Speakers:

Gail Levy, ADB & Associates
Robert E. Mazer, Esq., Ober, Kaler, Grimes and Shriver

Objectives: Participating physicians will understand

- the laws regulating sexual behavior in the office and policies and procedures that should be put into place to avoid allegations of sexual harassment,
- the laws regulating employment practices (hiring and terminations) and the office policies and procedures that should be implemented to avoid employee/employer disputes,

Hotel Information

The Princess Royale is Ocean City's newest luxury hotel.

All suites are two-room oceanview or oceanfront suites with private balcony, electronic safe, in-house grocery service, two color televisions with pay-per-view movies, video folio review and checkout, and two telephones. All suites are complete with a fully equipped kitchen with microwave, stove, refrigerator, ice maker, and dishwasher.

Guest check-in time is 4:00 p.m. Guests arriving before 4:00 p.m. will be accommodated as rooms become available. Check-out time is 11:00 a.m. Arrangement can be made for baggage storage beyond 11:00 a.m.



Saturday, Sept. 19 (contd.)

- personnel policies and procedures that promote effective practice operations, and
- staffing models and work assignments that promote efficient and effective practice operations.

Target audience: All physicians

CME Credit: 1.5

4:30 p.m.–6:00 p.m.

"OSHA Regulation in Physicians' Offices"

Speakers:

Robert J. Ancona, M.D., Chairperson, Immunizations and Infectious Diseases Subcommittee

Roseanne M. Matricciani, R.N., J.D., Assistant Executive Director for Health Care Policy, Med Chi

Objectives: Participating physicians will

- have an overall understanding of OSHA requirements,
- understand what an "inspection" entails,
- be able to utilize the OSHA Kit,
- be able to "service" an inspection with minimal disruption, and
- be able to deal with OSHA requirements with reasonable fiscal outlay.

Target Audience: All physicians

CME Credit: 1.5

4:30 p.m.–6:00 p.m.

"What Every Physician Should Know about Peer Review of a Medical Practice"

Speakers:

Ronald J. Cohen, M.D., Chairperson, Peer Review Management Committee

Sidney B. Seidman, M.D., Past Chairperson, Peer Review Committee and Member, Maryland Board of Physician Quality Assurance

Objective: Participating physicians will be aware of the more common deficiencies found in practice reviews conducted under the guidance of Med Chi's Peer Review Management Committee.

Target Audience: All physicians

CME Credit: 1.5

Sunday, September 20, 1992

7:30 a.m.–12:00 noon—Registration

8:30 a.m.–10:00 a.m.

"Assisting an Impaired Colleague"

Introducer:

J. Richard Lilly, M.D., Chairperson, Committee on Scientific Activity

Reservations

Med Chi has reserved a block of rooms at a special group rate. To guarantee your suite call 1-800-4-ROYALE (1-800-476-9253) and tell them you'll be attending the Med Chi Semiannual Meeting. *To receive the Med Chi group rate, your suite must be reserved by August 25, 1992.*

Parking

Free parking is provided for hotel guests. The Princess Royale has over 450 available spaces.

Telephone Messages

During the meeting, messages may be relayed to registrants by calling 410-524-7777.



Sunday, Sept. 20 (contd.)

Speaker:

Edson B. Moody, M.D., Member, Physician Rehabilitation Committee

Objectives:

 Participating physicians will

- be aware of the signs and symptoms of physician impairment,
- understand the process of referral to the Physician Rehabilitation Program,
- examine the impact of making a referral on the referring physician, and
- learn ways to appropriately use supporting measures in helping a colleague through the process of intervention and treatment.

Target Audience: All physicians

CME Credit: 1.5

8:30 a.m.—10:00 a.m.

"Third-Party Reimbursement Issues for Medical Practices"

Introducer:

Jose Martinez, M.D., Member, Committee on Scientific Activity

Speaker:

Gail Levy, ADB & Associates

Objectives:

 Participating physicians will understand

- the key issues confronting physicians today that relate to third-party reimbursement, billing, and collections, and
- operational procedures that need to be implemented in order to comply with the regulations and to maintain an efficient practice.

Target Audience: All physicians

CME Credit: None

10:30 a.m.—12:00 noon

"CLIA '88 Regulation in Physicians' Offices"

Introducer:

Carol Garvey, M.D., M.P.H., Secretary, Med Chi and Chairperson, Special Ad Hoc Committee on Physicians' Office Laboratories

Moderator:

Blair Eig, M.D., Member, Laboratory Advisory Committee, Maryland Department of Health and Mental Hygiene

Panel:

Carol Garvey, M.D., M.P.H.

Roseanne M. Matricciani, R.N., J.D., Assistant Executive Director for Health Care Policy, Med Chi

Blair Eig, M.D.

Eugene Shanholtz, Maryland Department of Health and Mental Hygiene

John DeBoy, D.P.H., Chief, Division of Laboratory Licensure, Certification and Training, Maryland Department of Health and Mental Hygiene

Continuing Medical Education Credit

The Medical and Chirurgical
Faculty of Maryland
designates this continuing
medical education activity for up
to 8.5 credit hours in Category 1
of the Physician's Recognition
Award of the American Medical
Association

The Medical and Chirurgical
Faculty of Maryland is
accredited by the
Accreditation Council for
Continuing Medical Education
(ACCME) to sponsor continuing
medical education for physicians.



Sunday, Sept. 20 (contd.)

Objectives: Participating physicians will

- understand the latest regulations affecting their offices under CLIA '88 legislation,
- receive timely printed material to assist in implementation of these regulations, and
- be given the opportunity to clarify details of CLIA '88 regulations through discussion and questions/answers.

Target Audience: All physicians who have or are considering starting office laboratories

CME Credit: 1.5

10:30 a.m.–12:00 noon

"Legal and Regulatory Issues for Medical Practices"

Introducer:

Jose Martinez, M.D., Member, Committee on
Scientific Activity

Speaker:

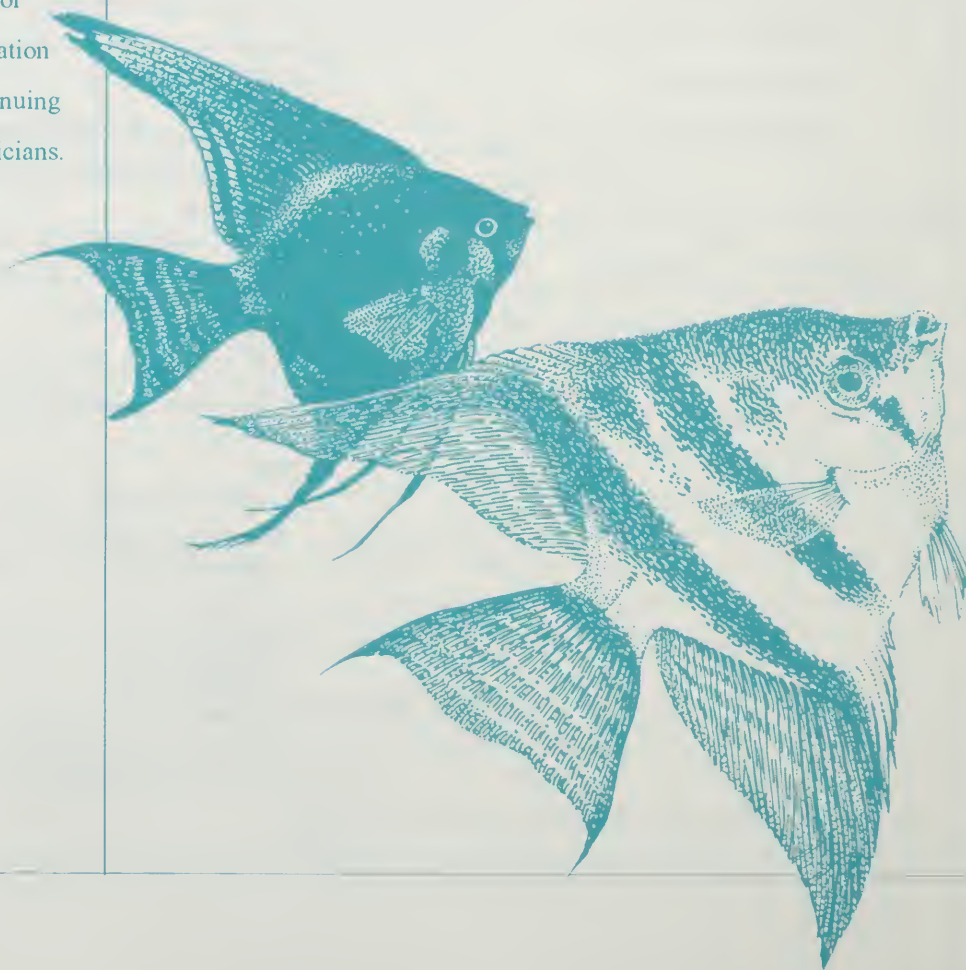
Robert E. Mazer, Esq., Ober, Kaler, Grimes and Shriver

Objective: Participating physicians will understand

- the key legal and regulatory issues confronting physicians today that relate to managed-care contracting, fraud and abuse, partnership and associate agreements, buy-sell arrangements and practice valuations.

Target Audience: All physicians

CME Credit: None



Executive Director's Newsletter

August 1992

Preliminary Program for Med Chi's 1992 Semiannual Meeting

Med Chi physicians are encouraged to register now for the 1992 Semiannual Meeting to be held on Friday, Saturday, and Sunday, September 18, 19, and 20 at the Princess Royale Hotel in Ocean City, Maryland. A Preliminary Program for this year's meeting precedes this *Executive Director's Newsletter*.

Physicians who wish to reserve a suite at the Princess Royale must call 1-800-4ROYALE (1-800-476-9253) by August 25, 1992 in order to receive the Med Chi group rate.

1992-1993 Med Chi Directory

The 1992-1993 *Med Chi Directory* was mailed to all active Med Chi members with this August 1992 special issue of the *Maryland Medical Journal*. If your membership status is Emeritus, Emeritus-at-large, Affiliate, Associate, Student, or Resident, you can request a free copy of the Directory by calling Wanda Griebel at 410-539-0872 or 1-800-492-1056. The Directory is available to nonmember physicians for \$85.00 plus postage.

Notice for Medicare Providers in Montgomery and Prince George's Counties from PA Blue Shield

Med Chi recently received the following notice from Pennsylvania Blue Shield for Medicare Providers in Montgomery and Prince George's counties:

This is to notify you that a problem has been detected in the printing of the summary vouchers that were dated March 27 through May 10, 1992. This concerns claims for psychiatric services subject to the 62.5 percent reduction only. The following summarizes the problem:

- The Medicare allowed charge in column 4 of your voucher is understated for the psychiatric claims. The amount shown is actually the amount after the psychiatric reduction has been taken.
- This incorrect amount in column 4 caused an incorrect printing of the beneficiary liability amounts in item A and item B on the voucher.

Although this information was listed incorrectly on your vouchers, the actual amounts paid on these claims were correct. Therefore, the adjusted payments are not needed for these claims. In addition, this information on your patients' Explanation of Medicare Benefits statements (EOMBs) for these services was correct. As such, no additional information will be provided to the patients on this issue.

We realize the importance of accurate information so that you can correctly bill your patients. We are, therefore, providing you with duplicate copies of your patients' EMOBs, accompanied by a cover page showing your name and mailing address. In order to determine your patient's liability on these claims, add the amount shown as the psychiatric reduction to the deductible and co-insurance amounts. This sum is the amount you can bill the patient for these approved services. This information will reflect what was shown on the patient's original EOMB.

We apologize for any inconvenience this matter may have caused you. If you have any questions regarding this information, please call (717) 731-2333.

DEMPAQ Update

DEMPAQ, a three-year collaborative project to develop methods to review the care provided to Medicare beneficiaries in physicians' offices, has completed the review of office practice records of participating Maryland physicians. Ninety-one Maryland physicians participated in the study and 1,750 records were reviewed. Results of the study are not yet available.

OSHA's Bloodborne Pathogens Standard

The AMA, along with state and county medical societies, is calling for the Occupational Safety and Health Administration (OSHA) to make changes in the bloodborne pathogens standard by

- Reducing the 30-year recordkeeping requirement;
- Adopting a one-year grace period for physicians who are making good-faith efforts to comply;
- Conducting a cost/benefit analysis of the standard as it applies to physician practices; and
- Reconsidering the penalty structure.

Med Chi is following this issue closely and will print further developments in the *Executive Director's Newsletter*.

MOSH/OSHA Seminars

The Division of Labor and Industry is conducting **free** seminars on the MOSH/OSHA Bloodborne Pathogens Standard. All training sessions will be offered from 9:00 a.m. - 12:00 noon at the following sites:

Tuesday, August 4, 1992

State Highway Administration Office
9300 Kenilworth Avenue
Greenbelt, MD 20770

Wednesday, August 26, 1992

Southern MD Electric Cooperative, Inc.
Route 231
Hughesville, MD 20637-1937

Wednesday, September 2, 1992

State Highway Administration Office
Route 291
Chestertown, MD 21620

Wednesday, September 9, 1992

Maryland Rehabilitation Center
2301 Argonne Drive
Baltimore, MD 21218

To reserve your place at the seminar, send the name of your organization, the name of a contact person, your address, your telephone number, the date of the seminar you are interested in attending, and a request for directions to the seminar to:

Division of Labor and Industry-MOSH
Training and Education
501 St. Paul Place
Baltimore, MD 21202
Attention: Cathy Carter

President's Regional Conferences

Med Chi has set dates for two President's Regional Conferences this fall:

Western Maryland—Thursday, October 22, 1992
at the Sheraton in Hagerstown, Maryland

Eastern Shore—Thursday, November 5, 1992
at the Cambridge Yacht Club in Cambridge, Maryland

Med Chi is currently surveying area physicians to determine subjects of local concern and topics for a continuing medical education presentation at the meeting. Physicians are strongly encouraged to complete these surveys and attend their regional meeting. For questions regarding these President's Regional Conferences, contact Joan Mannion at 410-539-0872 or 1-800-492-1056.

Membership Survey

In the coming weeks Med Chi will be sending a membership survey to a representative sample of Med Chi members. The survey will ascertain physicians' attitudes on Med Chi benefits, and various health care issues, and assess physician practice patterns. Med Chi members who receive this survey are strongly encouraged to complete the survey and return it to Med Chi as soon as possible.

Med Chi Helps Promote Breast Cancer Awareness

Physicians driving down Route 50 on the way to the 1992 semiannual meeting should pay special attention to the billboards along the way. Med Chi recently joined in an effort with the Med Chi Auxiliary to promote breast cancer awareness by helping to purchase two billboards developed by the American Cancer Society in conjunction with the Southern Medical Association Auxiliary. A total of ten billboards will appear around Maryland that contain the message: "Your chance of getting breast cancer is one in nine— Mammography—Your most powerful weapon." The two Med Chi-sponsored billboards will be along Route 50 during the month of September 1992.

Third Annual Conference on Addiction and Physician Health

The "Third Annual Conference on Addiction: Physician Health and Education" will be held on Saturday, November 21, 1992 in the Med Chi Faculty Building. Sponsored by the Med Chi Physician Rehabilitation Committee, this conference will feature sessions on prescription drug abuse, litigation stress, and the effect of tobacco on psychotropic medications. Plenary sessions will address the following topics: What is addiction, patient placement criteria manual, identification and treatment of the substance-abusing patient, and an update on how to help your patients stop smoking. For more information about this conference, watch the *Executive Director's Newsletter*.

1993 Med Chi Annual Meeting

Mark your calendars! Med Chi's 1993 Annual Meeting will be held on Friday-Saturday, April 30-May 1, 1993 at the University of Maryland University College Conference Center in College Park, Maryland. Watch the *Executive Director's Newsletter* for more information about this meeting.

Eligibility Verification System

Following this newsletter is information on how to use the Medical Assistance Program's Eligibility Verification System (EVS). This system was recently enhanced to allow physicians to quickly verify a Medicaid recipient's eligibility status. Med Chi physicians are encouraged to tear out these instructions for use in their medical office.

Aid to Families with Dependent Children Program

Below is a bulletin from Department of Health and Mental Hygiene Secretary Nelson J. Sabatini regarding the new Department of Human Resources (DHR) Aid to Families with Dependent Children Program:

July 22, 1992

Dear Primary Care Physician:

The Department of Human Resources (DHR) is reforming the Aid to Families with Dependent Children (AFDC) Program. The purpose of the reform is to encourage recipients to take actions for themselves and their children that may improve their health and welfare. These actions include preventive health visits and school attendance. As a MAC provider, you play a key role in meeting the primary health care needs of low income women and children. This letter describes your role in AFDC reform.

Starting in January 1993, DHR will reduce welfare payments to most fami-

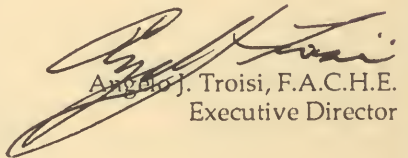
lies whose preschool children have not received a check-up in calendar year 1992. Before mid-December 1992, recipients must present their Department of Social Services workers proof that such a visit has occurred for each of their preschool children. We have enclosed ten copies of the form recommended for this purpose. It is a multi-purpose form. Only the preschool portion is required during calendar year 1992.

If you provide or have provided a check-up for a child in calendar year 1992, you or your designated representative should sign and date the form in the appropriate place and give it to the recipient. We suggest that you keep a copy of the completed and signed form in the child's medical record to save time if the form is lost by the parents.

Medicaid will pay you \$50 for an initial screening visit (W9075 CPT code) or ongoing screening visit (W9077 CPT code). There is an additional reimbursement for immunizations and for developmental, vision, and hearing tests that may accompany the visit. Medicaid will not pay you for simply collecting the form.

We very much appreciate your help in making this program work. If you have questions or concerns, please call your EPSDT/Healthy Kids Nurse Consultant at (410) 225-6750.

Sincerely,
Nelson J. Sabintini
Secretary



Angelo J. Troisi, F.A.C.H.E.
Executive Director

MARYLAND MEDICAL CARE PROGRAMS
Eligibility Verification System
USER'S GUIDE
November 1991

*Maryland State
Department of Health & Mental Hygiene*

INTRODUCTION

Effective November 2, 1991 the Medical Assistance Program is implementing a new, improved Eligibility Verification System (EVS).

EVS is a telephone-inquiry system that enables health care providers to quickly and efficiently verify a Medicaid recipient's current eligibility status.

A Medical Assistance, Pharmacy Assistance, or Qualified Medicare Beneficiary card alone does not guarantee that a recipient is currently eligible for Medicaid benefits. You can use EVS to quickly verify a recipient's complete status. To ensure recipient eligibility for a specific date of service, you must use EVS prior to rendering service.

EVS is fast and easy to use, and it's available 24 hours a day, 7 days a week. EVS takes only seconds to verify eligibility and during each call you can verify as many recipients as you like.

New enhancements to EVS provide you with the capability of verifying past dates of eligibility for services rendered up to 1 year. Also, if the Medical Assistance identification number is not available, you can now use the recipient's Social Security number and name code to obtain the ID number (for currently eligible recipients only).

The new system should prove to be an invaluable tool to Medical Assistance providers for ensuring accurate, timely eligibility information for claim submissions. If you need additional information, please call the Provider Relations Unit at 1-410-333-5399 or 1-800-492-5908.

YOU NEED:

- A touchtone phone
- The EVS access telephone number
- Your Medical Assistance provider number
- The recipient number and name code (or recipient Social Security number and name code)

HELPFUL TIPS:

- You must enter the pound sign twice (##) after entering data requested in each prompt.
- If you make a mistake, press the asterisk (*) button once. EVS disregards the incorrect information and repeats the prompt.
- If you do not enter data within 20 seconds after a prompt, EVS reprompts you. If you do not enter data within 20 seconds after the second prompt, EVS disconnects the call.
- To end the call you must immediately press the pound sign twice (##). Otherwise, your phone line will remain in service for 20 seconds allowing no other incoming calls.
- EVS provides current information up to the previous business day. If you need further assistance, call the EVS Hotline Monday-Friday between 8:00 a.m. and 5:00 p.m. at 1-800-492-5908. Be sure you listen to the complete eligibility status before ending the call so that you do not miss any of the EVS messages.

HOW TO USE EVS:

STEP 1: Call the EVS access telephone number by dialing the number for your area.

EVS Telephone Numbers:	Metropolitan Baltimore	1-410-333-3020
	Rest of Maryland	1-800-492-2134
	Outside of Maryland	1-800-638-5775

EVS answers with the following prompt:

"MEDICAID ELIGIBILITY SYSTEM, PLEASE ENTER PROVIDER NUMBER"

Once familiar with EVS, you may bypass the above initial message by going directly to Step 2. However, it is recommended that you listen to the complete message during your first call of the day since additional information may be provided.

NOTE: Magnetic strip card readers currently in use are not compatible with this system.

STEP 2: Enter your five-digit provider number and press the (#) button twice.

Example:

0 1 2 3 4 # #

EVS replies with the following prompt or an error message if an invalid provider number has been entered:

"ENTER RECIPIENT NUMBER AND NAME CODE"

STEP 3: Do one of the following:

For Current Eligibility:

Enter the 11-digit recipient number and the two-digit name code (the first two letters of the last name converted into numeric touchtone numbers) and press the # button twice.

Example: For recipient Mary Stern, you would enter:

<u>1 1 2 2 3 3 4 4 5 5 6</u>	<u>7 8</u>	# #
Recipient Number	Last Name Code*	

* Last Name Code - where 7 is for the S in Stern and 8 is for the T in Stern

NOTE: Since the characters Q and Z are not available on a touchtone phone, enter the digit 7 for the letter Q and digit 9 for the letter Z.

EVS will respond with current eligibility information or an error message if incorrect information has been entered.

For Past Eligibility:

You can optionally search a recipient's past eligibility status of up to 1 year. Do this by entering a date of up to 1 year using format MMDDYY.

Example: For recipient Mary Stern, where the date of service was January 1, 1991, you would enter:

<u>1 1 2 2 3 3 4 4 5 5 6</u>	<u>7 8</u>	<u>0 1 0 1 9 1</u>	# #
Recipient Number	Last	Service Date	
	Name Code		

EVS will respond with eligibility information for the date of service requested or an error message if incorrect information has been entered.

Should you enter the date incorrectly, EVS reprompts you to reenter only the date up to three consecutive times. However, at the prompt, you can return to the ENTER RECIPIENT NUMBER AND NAME CODE prompt by entering "9" and pressing the # button twice.

If Recipient Number Is Not Available:

If you do not have the 11-digit recipient number, at the recipient number prompt press "0" and press the # button twice. In this case, EVS prompts you with the following:

"ENTER SOCIAL SECURITY NUMBER AND NAME CODE"

Enter the recipient's 9-digit Social Security Number and 2-digit name code.

Example:

<u>1 1 1 2 2 3 3 3 3</u>	<u>7 8</u>	# #
Social Security No.	Last Name Code	

NOTE: Social Security Numbers are not on file for all recipients. Eligibility cannot be verified until the Medical Assistance number is obtained.

If you have entered a valid Social Security number, EVS will provide you with a valid recipient number, which you should record, and current eligibility status.

NOTE: EVS does not allow you to search **past eligibility** status when you use this method. To find past eligibility you will have to re-enter the recipient number and name code and date. EVS then validates the recipient number and name code and replies with an eligibility status.

STEP 4: Enter another recipient number or immediately press # # to end the call.

NOTE: It is important to end the call with # # to both free your phone line and free the EVS line for the next caller.

ELIGIBILITY STATUS MESSAGES

EVS issues one or more of the following eligibility statuses, depending upon the recipient's entitled benefits:

- **ALSO MEDICARE** - recipient is eligible for services but the provider must bill Medicare first, when appropriate.
- **DIABETES CARE (Diabetes Care Provider name and phone #)** - recipient is eligible and enrolled in the Diabetes Care program; contact the diabetes care provider identified if necessary.
- **ELIGIBLE, FEDERAL** - recipient is eligible for benefits and reimbursements from federal funds.
- **ELIGIBLE, LIMITED STATE** - recipient is eligible for benefits and reimbursements from state funds but has some service limitations.
- **ELIGIBLE, STATE** - recipient is eligible for benefits and reimbursements from state funds.
- **HAS OTHER INSURANCE, CALL 225-1765** - recipient is eligible but has other health insurance through a third-party insurance company (example, Blue Cross). The insurance company should be billed prior to state Medicaid.
- **HMO (HMO name & phone #)** - recipient is eligible for services and a member of a health maintenance organization in the Medicaid program. Only the HMO should provide services other than emergency. Contact the HMO identified if necessary.
- **HOSPICE CARE (Hospice Care Provider name and phone #)** - recipient is eligible and enrolled in the Hospice Care Program; contact the hospice provider identified if necessary.

- **INVALID NAME CODE** - recipient number is correct but name code does not match the name code on file. EVS will repeat the information to you; please compare it with the original information.
- **INVALID PROVIDER** - provider number is not on the provider file. EVS will repeat the information to you; please compare it with the original information.
- **INVALID RECIPIENT** - either the recipient number was entered incorrectly or recipient is not eligible. EVS will repeat the information to you; please compare it with the original information.
- **INVALID SOCIAL SECURITY NUMBER** - Social Security number is not on file, was entered incorrectly, or recipient is not currently eligible. EVS will repeat the information to you; please compare it with the original information.
- **MAC PROGRAM (Primary Care Provider name and phone #)** - recipient is eligible and enrolled in the Maryland Access to Care (MAC) program; contact the primary medical care provider identified if necessary.
- **MANAGED CARE, RESTRICTED (Managed Care Provider name and phone #)** - recipient is eligible for services but is restricted to chosen providers under the Managed Care Program. Only emergency services should be rendered by other providers. Contact the managed care provider identified if necessary.
- **MEDICARE ONLY** - recipient is eligible and is a Qualified Medicare Beneficiary (QMB). Provider must bill the Medicare carrier first.
- **NOT ACTIVE THEN** - recipient was not eligible for services on the date you specified.
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The Academy Movement

A History of the Origin of the American Academy of Psychoanalysis

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Dedication

To all those, mentioned or not, whose lives have been touched in major or minor ways in ever widening circles, directly or indirectly, by the unfolding events herein, then, now, or henceforth, including families, colleagues, students, and friends.

Henry P. Laughlin, M.D., Sc.D., Sc.S.D.

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The Academy Movement

Preface

The history of organized psychoanalysis is of relatively recent origin. Essentially, it began shortly after Dr. Sigmund Freud addressed a group of distinguished professionals at Clark University in Worcester, Massachusetts, in September 1909, at which time he received his only honorary degree.

The American Psychoanalytic Association was founded in Baltimore in May 1911, with Dr. James Jackson Putnam as president and Dr. Ernest Jones as secretary.* All of the founders were members of the American Psychopathological Association. One year earlier, in April 1910, the International Psychoanalytic Association came into being.

Reasons for the ready reception and rapid spread of psychoanalysis in the United States have been presented in many articles and books. It is paradoxical that the analytic movement in the United States, a country that Dr. Freud disliked, brought him the recognition and fame he was initially denied elsewhere.

Americans love organizations, believing that identifying a problem and attacking it with energy and enthusiasm can solve it. Dr. Henry P. Laughlin, having

* Historical Note: It may be of interest to the Maryland medical community that this event transpired in May 1911 in Baltimore. Dr. Putnam (1846-1918) was from Boston where he had long been a leading figure in American neurology. A recognized clinician and prominent medical author, he did not survive long to serve in his founding role and leading administrative position.

Dr. Jones (1879-1958) was considerably younger. A pioneer in the field, he organized, with Carl Jung, the first psychoanalytic congress in 1908 in Salzburg, Austria, where he first met Freud. Jones came to Canada the same year for a four-year tour at the Toronto General Hospital, returning permanently to England in 1913, where he became an increasingly significant figure in the young but burgeoning field of psychoanalysis. Here he occupied a leading position for decades, eventually authoring his masterful three-volume biography of Freud, whom he knew for 31 years and who made available over 3,600 of his letters.

Sigmund Freud, the founder of psychoanalysis, was born May 6, 1856 in Freiberg, Moravia, which is today part of Czechoslovakia. At age 4, he moved with his parents to Vienna, where he lived until age 82. After an incident in which the Gestapo held his daughter Anna—later to become famous in her own right as a child analyst in London—Freud, as a Jew, "saw the handwriting on the wall," and left for Paris on April 2, 1938. The family ultimately settled in London, where Freud died of cancer on September 23, 1939 at the age of 83.

The United Kingdom was the final overseas destination in the first of the author's world lecture tours.^{34,35,36,37} In December of 1954, Dr. Laughlin visited Dr. Jones, who was by then 75 years of age, at his home in Surrey, south of London. The galley of a volume of *The Life and Work of Sigmund Freud: 1953-1957* had arrived, and it was Dr. Laughlin's privilege to proofread some of the pages. Another interesting vignette during Dr. Laughlin's visit with Jones highlighted an intriguing facet of Jones' complex personality. Jones had recently been presented with an unusual clock. He told Dr. Laughlin about his pleasure in receiving this gift, which would require winding in 400 years. He gravely reported how he had inserted a provision in his will directing this to be done on the required date. Jones appeared to have not the slightest doubt that this would transpire in the distant future (approximately 2350). We may wonder whether it will indeed.

identified a need for a more open forum for psychoanalysis acceptable to younger analysts, was a prime mover in the formation of the American Academy of Psychoanalysis. Since they served a common purpose, the coordination of many independent, sometimes competing, analytic institutions seemed a desirable goal.

Dr. Franz Alexander says the Academy developed "as a reaction against the conformist trend" and it was not a federation of analytic societies so much as a forum for the exchange of ideas by members of different psychoanalytic training institutes representing differing viewpoints.*

Dr. Laughlin served as the administrative mechanism starting a number of significant professional organizations, including the American Academy of Psychoanalysis. Dr. Laughlin understands the system from which organizations develop, and it is his personal charm that attracts movement leaders to the logic of that system. He demonstrates skill in enrolling prestigious heads of groups to work together. There is no evidence that the scientific preoccupations of the Academy were superior to other forums for psychoanalytic thought. However, the timely choice of topics and the satisfying social interchanges led the Academy to send down roots that have flourished into the healthy organization it is today.

There is value in recording significant recollections in the development of movements and organizations that enshrine ideas. Today, people seldom write revealing letters or record private thoughts on matters later to be recognized as of historical value, particularly those that lead to a new institutionalization of purposes and procedures. All of us tend to avoid unpleasant statements that might embarrass or estrange fellow workers. Perhaps one reason Ralph Nader is so successful is he gives voice to the frustrated, faceless mass of human beings who lack the courage to challenge the status quo. Organizations must change to survive. More than accommodation to confrontation and criticism is required. Organizational leaders must rethink goals and objectives, finding more ways to involve many individuals in the development of new strategies and activities.

Leaders must stand back and evaluate process and achievement. What does study of organizational objectives reveal? Is the organization on target? Are there reasons and solutions for the perceived unmet needs? Is it possible to redirect energies to strengthen the institutional structure?

This account traces the beginnings of the American Academy of Psychoanalysis, providing the baseline against which the achievements of that organization may be measured in another decade or two. The dynamics of a movement's growth have seldom been recorded while founders are still living. It is a practice to be encouraged when there is reason to believe in the importance of the movement.

Walter E. Barton, M.D.

* Alexander, FG Selesnick ST. *The History of Psychiatry*. New York: Harper and Row, 1966; 412.

The Academy Movement

Foreword

A Significant Chapter in the History of Psychoanalysis

These notes have been set down to describe a significant chapter in the history of American psychoanalysis. Herein are the names of pioneers who had the foresight, interest, and courage to make personal commitments to the Academy Movement and establish the concepts and philosophy of the American Academy of Psychoanalysis.

This account of the Academy Movement was written while the early files, records, correspondence, and recollections were still intact.^{1,2,33,56} Because the help of others has been valuable, it was important to complete it before the pioneers who have already been lost (p.726) are joined by other leaders in the Movement.

From 1947 to 1951, I recognized the need for a new national psychoanalytic organization, envisaging the constructive functions it could subserve. The timing was propitious. As the concept became clearer, appropriate research led me to select, adopt, and introduce the term "Academy." This was probably its original professional or organizational usage in America (p.692). As the founder of the Academy Movement, I organized its central group, the National Committee for Scientific Progress in Psychoanalysis (NCSPP), as an interim and predecessor organization for the planned American Academy of Psychoanalysis.

For years, I carefully fostered and promoted the Movement, mobilizing support from many friends and colleagues. Among other endeavors in this direction, I wrote and circulated the *NCSPP Newsletter* and drafted a preliminary Academy constitution.

I originally undertook writing this history in May 1958 at the behest of Dr. John Alfred Parsons Millett who had just been named president-elect of the Academy in San Francisco. At the end of that summer, the resulting manuscript was promptly sent to him. During subsequent years, however, he mislaid this document. In 1966, Dr. Millett was named Academy historian and was assigned "the task of writing up a formal history of the Academy's first ten years." Recalling the earlier manuscript, he again wanted access to this data,^{49,51} making a new request in August 1967. A copy of the original was forwarded to him with copies of early correspondence and records.*

Two years later, following interest indicated by other colleagues, a second draft was prepared with more detail. In the interests of accuracy and completeness, the

* This manuscript and file material was later acknowledged by Dr. Millett⁴⁹ as having been "of great use in preparing the introductory chapter in the Academy history."

manuscript was circulated to a score of early Academy Movement associates. Their editorial suggestions and supplemental data were much appreciated. The resulting improvements were reflected in a third draft in 1970, and to the extent of their welcome contributions, each reviewer shares authorship. Later, following several phases of circulation, review, and editing (pp. 742-3), the account was finally completed in its present form in July 1992.

The passage of years has made greater objectivity possible in appraising events, allowing more of the story to be told. Added detail also became feasible as many previously conflicting viewpoints have been, in part, resolved. More material could be included, but in the interest of brevity, the present account will suffice.

For several reasons, the following account focuses on the original endeavors, for which some of the personal contacts, meetings, and people will be described. First, only a handful of early compatriots know the full story of the early days. Second, the account may hold interest for members of the Academy or others with a historical bent. Third, it was intriguing to research and chronicle the earliest contacts and individual contributions made on behalf of the Academy. Finally, the account merits preservation, especially since it is uncommon that such complete data have been maintained during the evolution of a major professional movement.

In any event, writing about the history of the Academy will now be easier. More complete records have been kept, dating from the time of the final chapter of the Academy's founding in Chicago in 1956. Also, there are a great many competent people, like Dr. Millet, to undertake its authorship.

It has been challenging to research the dates of the early pioneers' initial contacts with the Academy Movement (p. 741). Careful study of the correspondence and records^{1,2,56} provided an unusual opportunity to document the specific times, means, and circumstances through which most of them first became cognizant of, and many committed to, the Academy concept. Those who became charter fellows of the Academy are indicated with a plus sign (+) on first mention. Others included in the history also played prominent roles. Full names generally are used only upon first mention.

This account is likely to hold particular interest for surviving pioneers of the Movement and early participants in the Academy. For these people, this paper may help recall some of the excitement, struggles, successes, problems, satisfactions, and heartaches of a significant era in psychoanalysis. For others, the inclusion of biographical notations, footnotes, a few reminiscences, and personal vignettes will increase its interest and perhaps enhance the prospect of its continued value.

This history may also prove intriguing for those who have heard about some of the earlier leaders in American psychoanalysis. Some notable interrelationships are recounted. There are also a few scattered nuggets of information not readily

available elsewhere about the early leaders' backgrounds, training, careers, and occasional foibles. These are worthwhile inclusions since a large percentage of any history includes biographies and descriptions of those involved, including individual reactions, interactions, and personalities. With early records still extant, it was possible to include considerable detail.

Note that the following account is written in the third person as a less personal approach. I hope that each reader will find something of interest and that copies of this account will be preserved as a modest contribution to the history of the field.

Henry P. Laughlin, M.D., Sc.D., Sc.S.D.

Acknowledgments

Acknowledgment is gratefully made to all with whom earlier correspondence^{1,56} provided the opportunity to enhance records of events of the crucial first years of the Academy Movement. I wish also to thank scores of friends and colleagues who have reviewed this manuscript (pp. 742-3) since 1958² when it was in less than ideal condition. Their comments, editorial suggestions, supplemental data, and encouragement greatly contributed to the manuscript's preparation.

I give special thanks to Dr. Walter E. Barton, a friend of many years, for his excellent preface, and to Dr. Sidney Berman, a longtime friend and colleague whose commentary inspired the final draft of this history.

Acknowledgment is also made to the dedicated typists, whose contributions have been essential to the development of this historical account.* Finally, my gratitude goes to the *Maryland Medical Journal (MMJ)* editor, Dr. Victor R. Hrehorovich; to the managing editor, Janet Campbell; to the *MMJ* editorial board for its encouragement and support; to Med Chi's executive director, my great friend Angelo J. Troisi, for his encouragement and support; to the Medical and Chirurgical Faculty of Maryland (Med Chi) for this publication; and to Med Chi staff Kelly A. Reier for editing, and Virginia Carter and Susan Ventura for design.

Henry P. Laughlin, M.D., Sc.D., Sc S.D..

* These include Lenore McComas (1958), Eleanor Woodward (1967), Carol Wyman (1969-70), Jean Hubbard (1971), Becky Stanley (1991), M. Page Durkee Laughlin (1991-92), and Lori Robinson (1992).

The Academy Movement

The History of the Founding of the American Academy of Psychoanalysis

Purposes and Goals of the Academy Movement

The American Academy of Psychoanalysis was formally and officially organized in Chicago in 1956, an occasion which marked the successful culmination of six years of endeavors undertaken by a small but increasing group of dedicated leaders in the field. These preparatory years, combined with events of the preceding two decades contributing toward an increasingly receptive professional climate, comprise an important era in psychoanalysis. This is the period of origin and growth of what is termed the "Academy Movement."

The original goals of the founder were rapidly espoused by those supporters of the Movement to include

1. Fulfilling the increasing need for a freer and more open scientific forum in psychoanalysis—one which might better foster the formulation, objective study, and evaluation of new psychodynamic conceptions, theories, and research.
2. Establishing a new national professional association for psychoanalysts to afford them the privileges of membership, provide an opportunity for scientific and social exchange on a high level, and serve a unifying role in the field.
3. Encouraging the further acceptance and integration of psychoanalysis in the university setting, and facilitating improved communications between analysts and their colleagues in related medical disciplines.
4. Advancing the interest of psychoanalysis, in general.

During its formative years, the Academy rapidly made substantial progress in fulfilling these goals. Regular semiannual scientific meetings were immediately initiated and were characterized by their open forum, professional excellence, and friendly social functions. Various university training programs around the country have come to more widely reflect the influence of psychodynamic conceptions and principles. Today, many Academy members and non-Academy analysts hold faculty appointments.

A position of substantial organizational strength has been achieved by the Academy. By 1970, well over 500 physician analysts had been elected to membership and fellowship, including many men and women of substantial achieve-

ment, prominence, and leadership. They represented all major groups and schools of thought from all sections of the nation.

The Academy continues to make steady progress in its level of national professional prestige. A prominent role in psychiatry and psychoanalysis has been secured since 1947 through 1951, when its basic concepts were formulated.^{1,56} From this well-established base, it is clear that the Academy will continue to function in excellent fashion in the years to come, serving as a constructive force in psychoanalysis.

Let us, however, take several steps back in time to survey the overall background and events that contributed to the beginning of the Academy Movement. Some organizational developments in psychoanalysis were somewhat chaotic.

Trends in Psychoanalytic Organization

Analyst Emigrants

The needs that contributed to evolving the Academy Movement and the eventual organization of the American Academy of Psychoanalysis are found in recent history. Because of accounts elsewhere,^{43,50,61} this section is limited in scope and detail. Carefully note, however, that the events leading to World War II (WWII) served as strong stimuli for the emigration of European analysts to the United States during the 1930s, with an increase in the tempo of this trend as the decade advanced. Welcomed almost without exception, some of these people contributed a generous admixture of old-world authoritarianism to the burgeoning field of psychoanalysis in this country.

During WWII, military experiences led to a major upsurge of interest in psychiatry and its subspecialty of psychoanalysis. The number of professionals in the field expanded rapidly. The needs were great, interest soared, and there were many advances. However, some senior people and a growing number of younger colleagues believed the important aspects of scientific and organizational development in psychoanalysis were overly conservative and slow-paced.

Efforts at Liberalization

There were, of course, some sincere efforts among the membership to liberalize the American Psychoanalytic Association (APsaA) from within. One of the first to so endeavor was Dr. Leon J. Saul, a leading analytic author and teacher. He became an early supporter of the Academy Movement, a member of the National Committee for Scientific Progress in Psychoanalyses (NCSPP), and volunteered to help with policy in 1952. Together with Dr. Millet, who also "took considerable initiative in both,"⁶⁷ he reports efforts in this direction from the APsaA Committee on Theory and Practice of Psychoanalytic Training and also by the Hospital and University Group (HUG).

Dr. Saul states, "Support came from the outstanding liberals among the analysts, particularly those in leadership positions in universities and hospitals, e.g., Drs. Binger, Grinker+,²³ English, Alexander, Heath, Gaskill, Levine, Miller, Ham, and many others who believed that more liberal and less rigid professional attitudes and organizational policies were needed to facilitate constructive developments in practice, research, theory and training. Success, however was slight."*

Negative Views of University Training

A number of independent psychoanalytic groups and institutes evolved in the

* During this period, others also worked for reform from within. Some believed this might occur through a process of liberalization and gradual policy change. Others hoped for the evolution of more democratic attitudes through the leavening effects of taking in younger members.

Among the latter, Dr. Grinker, the Academy's sixth president and a long-esteemed figure in the field,²³ recalled, "I was still optimistic that the American [APsaA] could be reformed with the increment of young new members, but this was not possible. I therefore joined the Academy as a Charter Member." Later, the formation and existence of the Academy helped in part to achieve, as an external influence, what had not been possible through influences from within.

early days of the postwar era, and in several noteworthy instances, analytic training was brought into university settings. While the latter might have been hailed as a major achievement, "this movement into the universities was not welcomed by organized psychoanalysis as desirable and acceptable," but was largely criticized and opposed.^{1,8,40,41,43,53,59,62,67,69}

Despite such negative attitudes, pressure continued to grow toward liberalization, and progress was inevitable. Nonetheless, the conservative and restrictive influences exerted by the old guard of the national organization continued to be very powerful. Let us gain more perspective through another backward glance.

APsaA Reorganizations of 1932 and 1946

The old-line European influences were solidly supported by a similarly disposed segment of American analysts representing some two or three analyst generations. The resulting combination was an ultraconservative wing, which greatly influenced the 1946 reorganization of the APsaA. Prior to this major development, in June 1932, a new but more moderate and democratic constitution had been adopted.* This reorganized the APsaA into a federation of branch societies.** At this time, there were three original constituent societies in New York, Washington-Baltimore, and Chicago, with the Boston Society included a year later. The authority of the APsaA stemmed from its component societies, and as Dr. Silverberg later stated, it was never intended that the national organization exert any powers not given by the individual societies.

However, the resulting state of affairs was substantially altered with the 1946 reorganization. In the interim, some had come to believe the development of local autonomy was being overly fostered. The 1946 provisions of the reorganization afforded a great opportunity for those who wanted a strong, central authority. The new constitution was drawn up by a committee under the chairpersonship of Dr. Ernest E. Hadley.*** Under the constitution's provisions, the APsaA became an association of individual psychoanalysts, in which the preservation of strong central authority was fully assured. Firm control of professional and organizational matters was held by the officers and council.

*Apprehensive that
its position would be
threatened, the old guard
wanted to impose a
strong central authority.*

* Dr. Harry Stack Sullivan of Washington and New York was chairperson of the committee that worked for several years drafting the 1932 constitution. Dr. Sullivan was vice-president of the APsaA in 1930 and was a founding member of the Washington-Baltimore Psychoanalytic Society on May 27, 1930.

** The constitution was approved by the International Psychoanalytic Association at the 12th International Congress in Weisbaden, September 1932.

*** A leading figure in Washington psychoanalysis from its early days and an esteemed friend and colleague until his death in 1954, Dr. Hadley was a founding member of the Washington-Baltimore Psychoanalytic Society and served as its institute director from 1949 to 1954. He opposed the Academy Movement and the organization it sponsored. Dr. Hadley was secretary to the APsaA from 1931 to 1936 and was defeated for the presidency in 1952, following the recount of a tie vote. After Dr. Hadley's death, Dr. Edith Weigert, a capable and longtime liberal Washington analyst who early became active in the Academy, succeeded Dr. Hadley as director.

Effects of the 1946 Reorganization

Unprecedented powers were soon exercised over policies and training and over admission, which was previously an automatic process following an analyst's election to a constituent society. Academic rigidity increased.⁵¹ The discussion of scientific ideas, as well as the introduction of innovations in theory or technique, became greatly inhibited and, at times, professionally hazardous. As a consequence, the overall development of psychoanalysis stultified.

A newly established Board on Professional Standards replaced the Council on Professional Standing and was given the authority to pass on the qualifications of individual applicants. It was not long before the applications of some analysts were deferred, despite prior approval by their own societies.

Because of more stringent standards governing training institutes,⁵² periodic evaluations and inspections were made of the institutes of component societies. Several crusading orthodox board representatives exercised their responsibilities with undue vigor and, at times, with less than optimal tact. Also, the establishment of new institutes required formal board approval, contributing to professional conflicts and problems in New York, New Orleans, Washington, and Philadelphia.

The discussion of scientific ideas, as well as the introduction of innovations in theory or technique, became greatly inhibited and, at times, professionally hazardous.

Formation of Independent Groups

Innovations in training were frowned upon by the old guard and could seldom be discussed objectively. These problems led to strained relationships and, in some instances, to the disillusionment and embitterment of liberal training analysts.

One significant consequence of the foregoing developments and their inimical professional influences was seemingly unanticipated: the inevitable evolution of independent analytic groups that were so bitterly decried and criticized by some. Nonetheless, several had prospered, perhaps even more so because of the restrictive stance of the establishment. The value of cultivating a more liberal climate in psychoanalysis became increasingly evident to a concerned segment of professionals.

Washington Exemplifies Problems

Further internal struggles and schisms took place within APsAA component societies. In the Washington area, the divisive course of events that transpired in New York and Philadelphia did not occur, although there had been continuing internal differences and problems. These, however, became less urgent after 1946, when the more orthodox Freudian Baltimore group and the Washington analysts mutually agreed to form two societies and institutes.* The three principal factors contributing to the division into two societies were geographical distance, ideological divergences, and personality clashes. Following formal application, the APsAA approved the separation into two societies in 1947 and two institutes in

* The Washington-Baltimore Psychoanalytic Society was organized on May 27, 1930.^{29,57} It was one of the three original component societies of the APsAA in June 1932 and was admitted to the International Psychoanalytic Association in September 1932.

1955. Marked by some controversy, the latter followed earlier refusal in 1951, then two years of probation.

Led by Drs. Hadley, Lewis B. Hill, and William Victor Silverberg⁺, analytic training began in 1932, making Washington-Baltimore the fourth such program formally started in America, following the establishment of the New York Institute by a year, and those in Boston and Chicago by some months. The Washington-Baltimore Institute was established in 1940, authorized at the APsAA meeting in Cincinnati in May 1940, with Dr. Hill as director until he was replaced nine years later by Dr. Hadley.

The Washington group came to be incorrectly identified by many APsAA leaders as synonymous with the brilliant, but sometimes acrimonious and less-than-diplomatic, Dr. Harry Stack Sullivan* and his neo-Freudian theoretical constructs.⁵⁸

Perhaps because of this identification, there were serious problems between the Washington analysts and the APsAA hierarchy.

Although the leaders in Washington had been very prominent in the APsAA in the twenties, during the following two decades their relationship and position within the national association became increasingly difficult—an unfortunate state of affairs that extended into the fifties. At times, secession from the central authority was advocated by some.** The quality, orthodoxy, and status of the Washington training program came under attack, and, on occasion, its approval may have been in jeopardy. As a consequence, after the 1946 reorganization, the central body's action on the applications of some duly elected members of the society was deferred,⁵⁸ and the acceptance of Washington analysts for membership was almost completely cut off for a period.

These fratricidal conflicts inevitably had negative repercussions, impairing relationships and threatening the professional standing for individual psychoanalysts in Washington and elsewhere. Their student-colleagues were also affected. Some believed the professional problems suffered by their seniors were being taken out in varying measure on them.

Similar dynamics might also have adversely influenced the sponsorship ties by Washington of Dr. Clara Mabel Thompson⁺ and her associates in the William A. White Institute in New York City, which after several years (1948-52) of complex difficulties were finally terminated (p.705). In any event, these

*The quality, orthodoxy,
and status of the Wash-
ington training program
came under attack, and,
on occasion, its
approval may
have been
in jeopardy.*

* Out of favor with some during this era, Dr. Sullivan had been very much respected in earlier APsAA circles. He was twice elected to terms on the Executive Council (1927 and 1929), was vice president as noted, and on the illness of the president—Dr. William Alanson White—presided at the 1928 meeting. It was not until after 1935 that Dr. Sullivan came into disfavor within certain circles in the APsAA.

Dr. Sullivan died in 1949 while attending a World Mental Health Congress in Paris. "Immediately following his death," one observer³¹ recalled seeing Dr. Frieda Fromm-Reichmann, who "was especially close to him...frantically trying to work out a new schedule to include his patients."

** During these difficulties, Drs. Hadley and Weigert are credited with "helping to keep the Society and parent organization together."⁵⁸

problems, perhaps typified by the Washington area and other analytic centers,* seemed unnecessary.**

Academy to Reverse Divergence

These problems unquestionably led to a wasteful diversion of professional energies, sometimes of colossal proportions. A fair number of excellent people increased their receptivity to constructive proposals for change.

The thought and planning that entered into the Academy concept was essentially constructive and progressive. It was intended to reverse the increasing trends of several decades toward professional and organizational divergence. Accordingly, the Movement adopted prominently the significant aim of fostering unification in psychoanalysis. As the forties waned, the time was indeed ripe for the Academy concept to evolve.

* Dr. Robert T. Morse, who had full access to the records, reported prior to his death (February 18, 1964) that "after careful inquiry" he had learned that during this period (1950s), "a substantial number of applicants for APsA membership were being deferred from other institutes."^{2, 54}

Dr. Morse, who remained the author's longtime friend and colleague throughout his life, opposed the Academy Movement. He was treasurer of the APsA from 1953 to 1957.^{19, 54} He was Dr. Laughlin's immediate predecessor as chairperson of the Public Information Committee of the American Psychiatric Association (APA).

** Note that those who were most active and regularly attended meetings of the Washington-Baltimore Psychoanalytic Society during the early years (1930-35) included Drs. Nolan D.C. Lewis, Hill, Weigert, Hadley, Andrew Evans, Alice Heyl Kiessling, White, Silverberg, Ralph Crowley, Lucille Dooley, and, later, Dexter M. Bullard Sr., and Fromm-Reichmann. These meetings, often enlivened by some rather intriguing social aspects, were usually held at Dr. Hadley's home or office, later at Dr. Bullard's, and after the arrival of Dr. Fromm-Reichmann, at her house at Chestnut Lodge.

Several times the group journeyed to Sheppard Pratt Hospital in Baltimore for a meeting. Here some of them met for the first time Dr. Sullivan, who, according to one member, "never was at all popular with our group." Dr. Keissling³¹ wrote, "It was a surprise and rather a shock for me to discover later that he had acquired quite a following among the Washington [analysts]. Now the pendulum has swung again to more conservative leaders, but for a while it was purely Sullivan oriented." Although some might question the extent of Dr. Sullivan's influence, he usually had a substantial impact on the people with whom he came into contact, and few were neutral in their reactions to him.

Academy Concept Evolved

Prior to 1949, Dr. Laughlin of Washington, DC, the founder of several other psychiatric and psychoanalytic organizations,* began thinking seriously in terms of a new and independent organization.

He gradually became convinced of the need to afford American psychoanalysts the choice of affiliation with an alternate national professional association. Other analysts must have also given some independent thought to the potential values inherent in having a new group.** However, Dr. Laughlin initiated the movement which proved definitive and eventually came to fruition with the formal establishment of the American Academy of Psychoanalysis about six years later. He first promoted the Academy Movement, named the concept, and mobilized early interest and support for establishing the Academy.^{1,2,17,33,47,52}

...fundamentals for the organization's success would include its high caliber of membership, open scientific forum, excellence of programs, and overall merit as a scientific body.

Gradually, Dr. Laughlin became certain that an entirely new organization should be brought into being that would reflect fresh, liberal, and broad viewpoints. It had to be unrelated to the existing national group with its solidly entrenched conservatism, authoritarianism, and involved internal politics. On the other hand, the new group would welcome the affiliation of APsaA members who supported the more liberal Academy ideals and principles, as well as those who were prominent in several excellent non-APsaA psychoanalytic groups.

The founding group would be comprised of interested leading liberal members of the senior association as well as independent groups. As outlined earlier, fundamentals for the organization's success would include its high caliber of membership, open scientific forum, excellence of programs, and overall merit as a scientific body.

The founder concluded the greatest need in psychoanalysis was to create this kind of scientific meeting ground for the more progressive and liberal leaders in the field. To achieve this, an entirely new organization would be required. With its establishment, benefits of membership would be available to all analysts on an equal basis. As time passed, he became certain that this was a sound conception and that substantial support could be mobilized as more liberals in the field were convinced that it could succeed. This concept was further developed and delineated over the next two years. Dr. Laughlin was then able and ready to

* Dr. Laughlin was co-founder of the Washington Psychiatric Society in 1949;^{7,30,39} founded the Metropolitan Washington District Branch of the APA in 1953; and organized the Modern Founders of the APA in 1958, the Eastern Psychoanalytic Association in 1962¹⁸ (which became the American Society of Physician Analysts by 1976, merging with the American Association of Psychoanalytic Physicians to become the American Society of Psychoanalytic Physicians), and the American College of Psychiatrists (ACP) in 1963.⁷¹ He was co-founder of the Maryland Chapter of Psychiatrists (SMCP) in 1968.³⁸ He founded the American College of Psychoanalysts (ACPSa) in 1969,^{5,28} serving as its first, sixth, and beginning on May 12, 1979, honorary life president.

** In later confirmation of this supposition, Dr. Judd Marmor⁴⁴ mentioned that Drs. Abram Kardiner, Sandor Rado, Sullivan, Erich A. Fromm, and Franz Alexander entertained such ideas "as far back as 1940, which came to naught." Dr. Marmor was the tenth Academy president during 1965-66.

test professional sentiment. In the winter of 1951, he actively advocated the implementation of a new organization.

This process began quietly and selectively in the Washington area. Later, efforts became more widespread, the first major occasion in this direction taking place during the course of the Atlantic City meetings in May 1952. A number of prominent people there expressed interest, and later many more would also do so.

The Name

With little modification, the ideals and principles outlined here became the guidelines of the Academy Movement and reflected the attitudes and thinking of the majority of those who became charter fellows. As these principles became better delineated, the need for a name for the organization was apparent.

In 1951, Dr. Laughlin began searching for a suitable name. The usual names for medical and professional groups in the United States seemed to be overworked. That fall and early winter, research was undertaken at the National Library of Medicine in Washington, DC, where the names of all present and past medical, professional, and scientific bodies in various countries were surveyed.* Many

names were inappropriate, while others had been used too extensively or were not sufficiently distinctive. Among the names considered as possibilities, "Academy" posed none of these problems. But, a number of important considerations entered into its ultimate selection.

"Academy" had not been employed as the name for an organization in psychiatry or psychoanalysis and was used infrequently in other areas.** It stood out from other names. Further, it offered communication advantages of ready recall, easy spelling, and simple pronunciation. Finally, its professional connotations were excellent, and in Europe this name represented the acme in professional standing.

Although other candidates were considered, "Academy" became immediately prominent. Over subsequent months, a number of alternatives, including "Conference," "Council," and "Forum," were eliminated for various reasons, as were "Continental," "United States," and "International" as possible alternatives for "American."

"Academy" survived as the final choice and was clearly the best possible selection. There was later equivocation about "American," which was temporarily dropped in 1956 with the formal organization of the Academy,*** but readopted after 1966.****

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* This research led to Dr. Laughlin's selection and adoption of the name "Academy."

** A pioneering selection, "Academy" was used, to the best of the author's knowledge, exclusively in America in psychoanalysis. Dr. Laughlin originally introduced, adopted, and subsequently sponsored usage of the name in the United States. From the vantage point of the 1990s, its selection was a sound move.

*** The original name proposed in Chicago was the "American Academy of Psychoanalysis." Although "American," as well as "International," was claimed by vote, it was deleted when "Frieda Fromm-Reichmann objected from the floor to the label 'American' and proposed that we use the term 'Academy' [alone] with the hope that it would serve as an umbrella for members in other countries."⁶⁸

Dr. Robert S. Mumford of New York City and Old Greenwich, Connecticut became a friend and colleague in various professional endeavors and first met the Laughlins with Dr. Ed. Ziman at the 105th Annual Meeting of the American Psychiatric Association in Montreal, May 23-27, 1949. He reports, "Janet Rioch—who was my analyst—[also] proposed the brief 'The Academy of Psychoanalysis' for the same reason—[It] should be a universal umbrella. There was a rousing debate for several years. I believe the majority wanted to imitate the AmPsaAssoc [American Psychoanalytic Association] as closely as possible."⁵⁵

**** Actually, "American Academy" and "International Academy" were dually incorporated, so that each was reserved.¹⁴

However, the adoption of the name "Academy" was firm from March 1953. Dr. Laughlin used it exclusively from that period on and subsequently promoted its adoption by all enlisted in the Academy Movement. Accordingly, its employment was prominent in the June conference protocol of 1952 (p.708), provisional constitution drafts (p.707), the *NCSPP Newsletter* (p.711), and subsequent correspondence.^{48,56} Gradually, others accepted it, and, before long, a fair number were using the name "American Academy of Psychoanalysis."^{1,2}

This early judgment proved to be well vindicated in later years as the Academy Movement gained momentum and its ideals were discussed with psychoanalysts from all sections of the country. Most colleagues found the proposed name quite suitable and some, such as Dr. Joseph H. Merin,⁴⁸ were immediately enthusiastic. While only a few in the W.A. White group used it extensively for several years, many others did, and according to the records, only two (Dr. Saul H. Fisher on October 3, 1952 and Dr. George C. Ham on November 18, 1952) indicated reservations.* The choice was adopted in Chicago on April 29, 1956.

As expected, several colleagues sought unsuccessfully to change the name as a matter of principle. However, "Academy" was an excellent name and provided a distinct identity for the Movement. It was an appropriate name with scholarly connotations, which made it a valuable asset of the early participants in the Movement and aided their endeavors.**

* Dr. Ham²⁴ suggested the American Society for Psychoanalytic Research. Dr. Fisher²⁰ would have substituted "College" for "Academy."

** Since its introduction in 1951-52, a wider appreciation of its value in medical circles may have led to the adoption of "Academy" by a number of other significant specialty groups in the succeeding four decades. Proving a clear-cut connection between our adoption of the name as a direct precursor to its later choice by other professional groups might be fruitless. Nonetheless, each such adoption has vindicated the selection by Dr. Laughlin.

Early Support Enlisted

A Wider Scope

As mentioned, the first major occasion at which wider interest was sought for the Academy was the national psychiatric and psychoanalytic meetings held in Atlantic City, New Jersey, in May 1952. Prominent among the sympathetic leaders were Drs. Alexander Reid Martin+, Karen Horney, Thompson, Bernard Zuger, Albert Bryt+, and Merin.

Dr. Merin approved of the Academy's ideals and became an advocate. His encouragement and help, along with Dr. Masserman's, were important for the next several years. The latter had been suggested by Dr. Thompson as representing the most promising of the "three factions" in Chicago (others cited were led by Drs. Alexander and N. Lionel Blitzen.)*⁶⁹

*A score of the
Academy's founders
merit recognition for
early commitment and
support.*

A score of the Academy's founders merit recognition for early commitment and support. These include Dr. Merin, secretary (1958-61) and trustee (1966-69); Dr. Masserman, second president; and Drs. Martin, Thompson, Horney, Paul Lussheimer, Silverberg, Saul, Ralph M. Crowley+, Millet, Wolberg, Janet Mackenzie Rioch Bard+, Zuger, Ham, Robert G. Heath+, Russell R. Monroe+, Fisher, Sandor Rado, Bryt, Roy R. Grinker Sr., Judd Marmor+, Harold I. Lief+, Irving Bieber+, Elizabeth Kilpatrick+, Herbert Spiegel+, Kardiner, and more, including earlier Academy officers. During and after the Academy's gestation, this group of leaders in American psychoanalysis provided invaluable support, contributing time, thought, advice, and funds. They backed the Academy Movement during its vulnerable embryonic status, when such commitment could have exposed them to professional hazards. It was originally planned that the Academy unite the four principal independent groups—the American Institute for Psychoanalysis (AIP) and Association for the Advancement of Psychoanalysis (AAP), New York Medical College (NYMC), W. A. White Institute, and Tulane University—with liberal leaders from Columbia (such as Drs. Binger, Millet, David M. Levy, Rado,** and Abram

* Some would have added another, under the leadership of Dr. Max Gittelson.

** Dr. Rado was born on January 8, 1890, in Hungary, where he earned doctorates in political science and medicine. He became a close associate of Dr. Sandor Ferenczi, with whom he lunched or dined several times weekly for years. In 1922, Dr. Rado went to Berlin and was analyzed by Dr. Karl Abraham, director, Berlin Psychoanalytic Institute. In 1924, he became editor of *Imago and Zeitschrift* on Dr. Freud's invitation. He came to the United States in 1930 to help organize the New York Psychoanalytic Institute and served as director until he resigned in 1941.

Dr. Rado wanted to keep psychoanalysis in medicine and, as an outstanding liberal, believed its theories, boundaries, and development should be kept free, open-ended, and elastic. Like Drs. Adler, Jung, Bleuler, Ferenczi, and other leaders, he conflicted with Dr. Freud on at least two occasions, although their breach was not so complete. Ever dynamic and progressive, he was critical of his more orthodox and conservative colleagues, and he once wrote with telling force about how their "exclusive preoccupation with Freud's formulations—which Freud himself continuously changed and regarded as provisional—proves once again the accuracy of Goethe's observation: 'Every great idea as soon as it appears exerts a tyrannic influence. Hence the advantages that it produces are all too soon transformed into disadvantages.'"⁶¹

Among his many distinctions, Dr. Rado was the first professor and director of the Psychoanalytic Clinic at Columbia (1944-55), and with Dr. Millet, professor of psychiatry (and dean of the New York School of Psychiatry) from 1959.

Kardiner+), the Washington area, and an independent non-affiliated group, which included liberal psychoanalysts from centers across the nation, particularly Chicago, Los Angeles, and Philadelphia.

Initial endeavors were directed toward securing interest of leaders of the first four groups, enlisting as much support as possible. Included were Dr. Horney, leader and founder of the AAP and the AIP; Dr. Silverberg (until 1944)*; Dr. Lussheimer, president; Dr. Wanda Willig, secretary; Dr. Martin, past president of the AAP; Dr. Thompson,** principal founder (1943 and 1946***) and executive director; and, later, Dr. Crowley (who became a member of the Columbia group after resigning from the Washington Psychoanalytic Society around 1959) of the W.A. White Institute; Dr. Heath, department chairperson; Dr. Monroe, representative (so named by Dr. Heath, on September 30, 1952, for "our group in all matters dealing with the formation of the American Academy") of the Tulane faculty; and Dr. Bieber, president; Dr. Fisher, vice-president; and Dr. Merin (president, 1959) of the Society for Medical Psychoanalysis.) The latter society was established by Dr. Silverberg, who became the third Academy president, in 1959-60, at NYMC in 1944 (p.701).

This was essentially accomplished the first year. While levels of commitment varied, these leaders were convinced of the proposed Academy's value. The Academy Movement gradually gained momentum, and significant progress was made.

It was soon apparent that taking an entire group into the Academy Movement could be a complex undertaking offering certain disadvantages. With general concurrence, it was decided in November 1952 (Dr. Laughlin to Dr. Masserman on November 30, 1952, and reply on December 5, 1952;⁴⁶ to Dr. Thompson on November 3, 1952, and reply on November 26, 1952⁶⁹) that analysts would be elected individually, based on qualifications.¹

Organizationally, this proved to be sound judgment. Nonetheless, the foregoing groups and their senior members were an integral part of the Academy from the beginning. As we shall see, the leaders of one group later adopted a policy that new members of the Academy must first belong to the APsAA. This was unacceptable to the Movement's founder and most of the

While levels of commitment varied, these leaders were convinced of the proposed Academy's value. The Academy Movement gradually gained momentum, and significant progress was made.

* Dr. Silverberg left the group to establish the first medical school-affiliated psychoanalytic program at NYMC.

** Dr. Thompson resigned with others in 1943 in protest over the rescinding of Dr. Fromm's training privileges as a non-medical analyst, in a move purportedly promoted sub rosa by Dr. Sullivan. Dr. Thompson had been analyzed by Dr. J.C. Thompson in 1925-26,²² Dr. Ferenczi, and, later, by Dr. Fromm. Dr. Thompson was the new group's first vice president in 1941.

*** In 1943, Drs. Thompson, Fromm, Sullivan, Fromm-Reichmann, J. Rioch Bard, and David MacK. Rioch formed the New York Division of the Washington School of Psychiatry, which became incorporated as the W. A. White Institute in 1946. Their analytic trainees were enrolled in the Washington-Baltimore Psychoanalytic Institute until 1948, providing an avenue for graduates to become members of the APsAA. Dr. Mumford adds,⁵⁵ "In 1947 I became a student of the NY Division of the Washington [-Baltimore Institute] and as such was a dues-paying student of the American Psychoanalytic Association. Your term 'Footnote' is an understatement. A few years later I received notice that I was no longer a student of the APsAA. There was no explanation and no refund!"

nucleus of excellent people already mobilized. It was a divergence from the ideals and spirit of the Academy Movement, which had already generated a great deal of favorable sentiment.^{1,56} Such a policy was not acceptable to NCSPP members or other pioneers.

The AAP and the AIP

The leaders of the AIP and the AAP became early valued supporters of the Academy Movement. As an old friend, it was natural that Dr. Martin was the first analyst of the Horney group to be contacted, and it was through his good auspices that Dr. Laughlin originally discussed the Academy concept with Dr. Horney in early May.

Their meeting took place in Dr. Horney's hotel suite in Atlantic City on May 10, 1952. Dr. Horney,* then in her 67th year, had long been recognized as a foremost theorist, clinician, and leader in American psychoanalysis. Dr. Martin** introduced Dr. Laughlin as an old friend and compatriot in the APA who was known for his energy and organizational ability. Dr. Martin considered it highly likely that they would have strong mutual interests because Dr. Laughlin had developed some very interesting and constructive plans that would initiate useful trends toward the unification of psychoanalysis.

Dr. Horney was cordial, attentive, and eager to learn about the ideals and plans of the Academy Movement. She expressed concern about increasing professional divergences and the organizational morass in psychoanalysis. She indicated interest in fostering the Movement toward rapprochement, liberalism, and unification. Drs. Horney, Martin, and others were very encouraging, and the consensus of this stimulating conference was that Dr. Laughlin should proceed with deliberate speed.

Dr. Horney showed immediate interest, and the interest grew. She described herself as "seriously interested in your [Academy] enterprise."

The leaders of the American Institute for Psychoanalysis and the Association for the Advancement of Psychoanalysis became early valued supporters of the Academy Movement.

* Dr. Horney moved to New York from Chicago in 1934. Here, Monday evening dinner meetings were held with Drs. Silverberg, Sullivan, Thompson, and Horney on a regular basis. In 1936, she persuaded Dr. Thompson to leave the Washington-Baltimore Psychoanalytic Society (which on February 11, 1942, elected her and Dr. Sullivan as "ex-chartris" members, Dr. Sullivan having resigned the previous year) and join the New York Psychoanalytic Society. Dr. Thompson was also a training analyst in their institute from 1934 to 1941.

In 1941, following major disagreements, Dr. Horney joined Drs. Thompson and Silverberg in resigning from the New York Psychoanalytic Institute, and they formed the AAP, with the AIP set up as its training arm. Originally, charter members of the new group included Drs. Hadley, Benjamin Weininger, and Marjorie Jarvis from Washington, and Dr. Blitzen from Chicago. Later, Dr. Crowley, then secretary of the Washington-Baltimore Psychoanalytic Society, joined, and Dr. Sullivan was elected to honorary membership. However, following a hostile resolution by the APsAA, directed toward members affiliated with the AAP (in December 1941), the latter mentioned people resigned.

** Dr. Martin chaired the Leisure Time Activity Committee of the APA for years, while Dr. Laughlin served on the Public Information Committee, which he later chaired for four years. Dr. Martin wrote the first edition of *A Psychiatric Glossary* for the APA, aided in the selection of Washington as the central APA office and in the acquisition of the headquarters building, and served the APA in other capacities.

She became a strong advocate of the Academy concept.*^{1,2,27} In October, she discussed the Academy Movement at the fall meeting of the AAP and told her group about the creation of the NCSPP as an intermediate step. Following this occasion, the NCSPP received an official letter from the AAP, of which Dr. Willig was then secretary,⁷³ requesting to be kept "informed about progress." Dr. Horney recommended several leaders in the AAP for membership in the NCSPP,²⁷ and these were followed.

Contact was maintained with Dr. Horney by phone and letter even during her final illness, when she managed a last letter concerning the Academy. By early 1953, in large part because of her positive influence, several leading members of her association were members of the NCSPP (p.710). Serving on the editorial board of its newsletter was Dr. Martin, who had been personally recommended by Dr. Horney,²⁷ while Dr. Lussheimer became a member of the Subcommittee on Constitution and By-Laws.

Dr. Horney's death on December 4, 1952 was a great loss to the Academy Movement and in many other quarters. It was a great tragedy that she did not have the satisfaction of sharing in the further implementation of its goals.

Others who belonged to the AAP and AIP were also enlisted. Dr. Zuger, the managing editor of the *American Journal of Psychoanalysis*, for which Dr. Horney continued to be the titular editor in 1952,⁷⁵ was also one leader of this group originally contacted by Dr. Laughlin in May 1952. Interested, Dr. Zuger developed considerable enthusiasm and became a strong backer of the Academy. He had the interest and initiative to undertake the initial presentation of the ideals and philosophy of the Academy Movement to the AAP meeting in July 1952. He was also highly recommended by Drs. Horney,²⁷ Martin,⁴⁵ and Lussheimer.^{1,42} Dr. Zuger also became a member of the NCSPP in early 1953. In accepting his invitation to membership, Dr. Zuger volunteered for the Subcommittee on Organization.

Dr. Martin, who served as a trustee from 1958 to 1961, and Dr. Lussheimer became valued NCSPP members, as did Dr. Willig on January 10, 1953, serving in various capacities. Dr. Kilpatrick, elected one of the first trustees (1956-67), was recommended by Drs. Lussheimer and Horney and invited to NCSPP membership the following January. Other prominent AAP analysts, including Drs. Harold Kelman+ (a leader in the association and the AIP until his 1969 affiliation with Dr. Wolberg's Postgraduate Center for Mental Health), Nathan Freeman+, and Marianne Horney Eckardt+, became committed to the new organization. Each played a prominent role in the final organizational phases of the Movement and the subsequent leadership of the Academy.

* In confirmation, Dr. Zuger wrote,⁷⁵ "Soon after the Atlantic City meetings, in addition to Alex Martin, she was the one in our group most inclined to go along with your plan [for the Academy]." In his letter, he added, "As for myself, I am very much interested."

Each played a prominent role in the final organizational phases of the Movement and the subsequent leadership of the Academy.

The Washington Area

Developments in psychoanalysis in the Washington-Baltimore area, and the complex organizational and personality interplay involved, contributed to the background and origins of the Academy Movement. Since the Academy concept evolved in Washington and the Movement was launched from there, more prominence has been accorded to people involved in the fostering and development of psychoanalysis in the national capital area. Footnotes have been appended to amplify personal data where possible, especially concerning a number of psychoanalytic leaders.

Space allows only a limited number to be included, and since the primary focus of this account has been on the Academy Movement, it should be carefully noted that some extremely significant people in early Washington psychoanalysis, such as Drs. William Alanson White,* Phillip Graven (Dr. Hadley's analyst), Nolan D.C. Lewis,** and others can receive only this brief mention and acknowledgement. In the main, they were uninvolved in the organizational struggles and personality clashes that developed.

The interest of psychoanalysts from the greater Washington area developed as anticipated. Accordingly, the national capital area has been well-represented in the membership of the Academy. This is also reflected in the leadership of the

* Dr. White was a charter member and first president of the Washington Psychoanalytic Society in 1914. Superintendent of St. Elizabeth's Hospital from 1903 to 1937, he was co-founder with Dr. Smith Ely Jelliffe of the *Psychoanalytic Review*. He was president of the APsA from 1916 to 1919 and in 1928.

** Dr. Lewis was a highly respected friend and colleague for many years until his death at age 90 in Frederick, Maryland, on December 18, 1979. He first came to Washington in 1919 when he joined the staff at St. Elizabeth's Hospital, having graduated from the University of Maryland in 1914. He became active in the Washington Psychoanalytic Society, where he gave several early papers and was president in 1925. He was also active in the Washington-Baltimore Psychoanalytic Society (of which he was a founding member), was elected one of its first councilors, and served as an instructor in its first training program. After WWII, he was consultant to the Nuremberg war trials.

Dr. Lewis analyzed two prominent pioneers among the Washington psychoanalysts: Dr. Dooley (who in turn interested Dr. Thompson in psychoanalysis and working summers at St. Elizabeth's Hospital) and Dr. Kiessling from 1932 to 1935, who was analyzed in 1930 by Dr. Dooley and later became the second president of the Eastern Psychoanalytic Association from 1965 to 1966. Dr. Lewis left Washington in 1938 to become Columbia University's department chairperson, a post he held for many years until he went to the Psychiatric Institute at Princeton. In the early 1960s he moved to Frederick, Maryland. On July 13, 1964, he was elected an honorary fellow (seniority number 43), the highest honor given by the Washington-based Eastern Psychoanalytic Association.¹⁸ He was a founding fellow (seniority number 2) of the ACPsA in Boca Raton, Florida, on May 7, 1969 and served on its first board of regents.

Accordingly, Dr. Lewis must be included among a number of esteemed senior psychiatric compatriots, especially with Drs. Leo H. Bartemeier and Kenneth E. Appel—staunch backers and allies over the years. They and others aided in the early endeavors that successfully launched the ACP in 1963 and the ACPsA in 1969. Dr. Bartemeier was a founding fellow (seniority number 12) of the ACPsA on March 18, 1970 and a founding fellow (seniority number 40) of the ACP on May 8, 1963. Dr. Appel was elected a fellow (seniority number 119) of the ACP on May 8, 1963, and founding fellow (seniority number 15) of the ACPsA on April 8, 1970.

Dr. Kiessling, long active in Washington-Baltimore analytic circles and a longtime loyal friend and backer of Dr. Laughlin, was president of the original Eastern Psychoanalytic Association and, along with Dr. Lewis and others, became a founding fellow (seniority number 6) of the then nascent American College of Psychoanalysts.

organization in which seven prominent Washington analysts served as trustees. Alphabetically, these are:

- Dr. Dexter M. Bullard, Sr. (1963-66)
- Dr. Paul Chodoff* (1964-67)
- Dr. Marianne H. Eckardt (1961-64)
- Dr. Frieda Fromm-Reichmann+ (until her death on April 28, 1957)
- Dr. Leon Salzman+ (also treasurer, 1956-60, and president, 1964-65)
- Dr. Edith H. Weigert+ (1957-60)
- Dr. Edwin A. Weinstein+

As expected, a fair segment of liberal analytic leaders in the Washington-Baltimore area became fellows in the organization before the Academy had been long in existence. The author does not clearly recall Dr. Weigert's early contacts on behalf of the Academy, and only in a limited way, Dr. Salzman's contacts. While personal contacts in Washington-Baltimore circles were more feasible and were advantageous in facilitating communication, there are fewer extant copies of correspondence to supplement details from this important segment of activity.

*The concepts on which
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1950 and 1951.*

Dr. Eckardt, Dr. Horney's daughter, moved from New York to Washington during the early phase of the Movement, and on November 15, 1952, was duly elected to membership in the Washington Psychiatric Society. She was quite interested in planning the Academy^{1,17} and impressed by the spirit motivating the pioneers in the Movement. Dr. Eckardt offered favorable comments about Drs. Lussheimer, Martin, and others among her colleagues from the AAP in New York and was pleased that several had been taken into the NCSPP. Her presence in Washington was encouraging and constructive.

The concepts on which the Academy Movement were based were tested carefully, thoughtfully, and with some discretion during 1950-51. This was a gradual process facilitated by discussions with a few colleagues from the Washington area. By January 1952, several had developed considerable interest in the proposed Academy, which by then had been tentatively named (p.692), and the basic principles and planning had become more clearly delineated.

In retrospect, this early phase in the gestation process (1951-52) substantially benefited the Academy Movement. It was analogous to the preliminary phases that preceded the founding of other professional groups^{5,6,18,28,39,71} such as the American College of Psychiatrists (1952-61) and the American College of Psychoanalysts (1960-68).

It is interesting to recall a helpful occasion in Washington in late spring 1952. On May 24, following the Atlantic City meetings, a preliminary meeting was held

* Dr. Chodoff should have been a charter fellow in the Academy.¹³ Receiving a letter of invitation from Dr. Rioch Bard on October 28, 1955, he planned to be present at the NYMC meeting on December 3. He could not locate the meeting site and inadvertently missed this important organizational meeting.

in Dr. Laughlin's home at 4101 Stanford Street, Chevy Chase, Maryland—a Washington suburb.

Each topic that came under consideration evoked spirited discussion by those present. The minutes summarize the Chevy Chase discussions, which covered four major areas:

1. Dr. Laughlin's brief review of the history of psychoanalysis, with emphasis on the prior two decades, including trends in psychoanalytic organization (p.685).
2. The planning of an intergroup conference, scheduled to be held in Washington in late June (p.708). The agenda for this conference was outlined, and the value of area representation and participation noted.
3. The qualities most desirable in the functioning of a psychoanalytic association. Among these were the importance of an open and freer scientific forum, the encouragement of unifying trends in psychoanalysis, and the improvement of the intergroup exchange of ideas and relationships.
4. The background and goals embodied in the Academy Movement were presented and discussed with interest and enthusiasm.

The Washington area participants on this felicitous and stimulating occasion included Drs. Joseph Abrahams, Lester L. Burtnick, Bernard A. Cruvant, Laughlin, Seymour J. Rosenberg, Marshall de G. Ruffin, and a few others.

Several former Washington area analysts continued to keep in touch with some of their colleagues, providing useful opportunities for contacts with them about the Academy Movement. These included Drs. Ramon Fernandez-Marina⁺ of Santurce, Puerto Rico; Mary Julian White Hinckley (who by November 13, 1952, was described as "quite in sympathy"^{1,2} and Geneva Goodrich, both of New York City; and George Kriegman of Richmond, Virginia, one of the original invitees to the Intergroup Conference of June 1952. Dr. David MacK. Rioch, early interested in the Movement, discussed the proposed Academy on several occasions (including a long Fourth of July weekend cruise in 1952 aboard Dr. Daniel Blain's* yacht *Corysant*), was impressed by the amount of progress in November of that year (as was Dr. Edna G. Dyar⁺ a little later), and recommended several excellent people as potential supporters, including Drs. Waelder in Boston, Rado in New York, and Mohr in Chicago.

* Dr. Blain, medical director of the APA and longtime friend, was later elected a fellow (seniority number 367) by the ACP on January 6, 1972 and, shortly thereafter, a charter fellow (seniority number 57) by the ACPsa on April 6, 1972. Dr. Walter E. Barton was also an APA medical director (1963-74) and an APA past president (1961-62) in Washington, DC. An esteemed friend for many years, he authored the preface. He was elected on February 20, 1969 as a fellow in the ACP (seniority number 239). After retirement, Dr. Barton moved to Hartland, Vermont.

The New York Medical College

As mentioned, Dr. Silverberg,* with the backing of Dr. Stephen Jewett, then head of psychiatry, established a psychoanalytic program at the Flower-Fifth Avenue center of the NYMC in 1944. This was the first analytic program established as part of graduate training in a medical school.** It flourished because of, and in spite of, the professional climate in organized psychoanalysis. A training institute was established, and the Society for Medical Psychoanalysis (SMP) was formed.

Prior to these accomplishments, Dr. Silverberg achieved a historical position in psychoanalysis, being one of the eight founders*** of the Washington-Baltimore Psychoanalytic Society in 1930 (and later of the W. A. Institute). There he gave the first scientific paper, on October 18, 1930. In 1941, he was a founder of the AAP and the AIP. Dr. Silverberg was an excellent teacher and leader who inspired

a great deal of confidence and loyalty in his followers and associates, contributing to the successful development of the NYMC group. He was also a respected pioneer in the Academy Movement and other areas.

Dr. Merin was the first person contacted from the NYMC group. Dr. Laughlin originally informed him in Atlantic City about the Academy Movement. For a time, he was primarily responsible for disseminating information, enlisting support, and maintaining a constructive liaison with fellow members in the SMP. He was later joined by Dr. Fisher (who was taken into the NCSPP in December 1952) and Drs. Bieber, Silverberg, Lewis R. Wolberg†, and others.

During summer and fall 1952, there was significant feedback to the SMP about the Academy Movement through Dr. Merin. This included his circulation of the Washington Intergroup agenda, the early draft of the constitution, the *NCSPP Newsletter*, and copies of correspondence received by Dr. Laughlin, from Drs. Bieber, Fisher, and Bryt.⁴⁸ However, the original meeting devoted specifically to the Academy was held on October 31, 1952. It brought together three SMP leaders in New York—Drs. Bieber, Fisher, and Merin—with Dr. Laughlin from Washington.

This proved to be a constructive conference, resulting in more positive attitudes. Dr. Merin, who helped arrange the occasion and provided introductory information to Drs. Bieber, Fisher, and others prior to the meeting, later expressed some misgivings as to the effectiveness of his preliminary spadework, doubting that he "had been able to put across the Academy ideals and goals clearly."⁴⁸ Held at his

This was the first analytic program established as part of graduate training in a medical school. It flourished because of, and in spite of, the professional climate in organized psychoanalysis.

* Dr. Silverberg was born on July 26, 1897 in New York City, where he graduated from Columbia University Medical School in 1921. His psychiatric training included a year at Manhattan State Hospital (1924) and two years at the Berlin Psychoanalytic Institute (1928-30), where he was analyzed by Dr. Alexander. He returned to Baltimore where he was research director at Sheppard Pratt Hospital from 1930 to 1931 and took a leading role in the development of psychoanalysis in the Washington-Baltimore area. In 1941, he was the first president of the AAP.

** The program at Columbia University was undertaken the following year in 1945.^{9,10,15,62,66} Both have continued.

*** Those were actually at the founding meeting of the Washington-Baltimore Psychoanalytic Society on May 31, 1930. However, 14 analysts were named as charter members.⁵⁷ Dr. Silverberg, at age 33, was elected the first secretary-treasurer of the new group. He died at age 70 on October 10, 1967.

apartment at 132 East 72nd Street in New York, Dr. Bieber, then SMP president, was a gracious host.

The discussions about the Academy Movement, while providing motivation for the occasion, were also facilitated by an excellent dinner and the mutual interests of the principals. Communication was enhanced by the intimacy of a small group and the existing positive relationships, personal contacts, and cordial correspondence with Dr. Merin.*⁴⁸ Dr. Merin repeatedly described himself as enthusiastic about the Academy. Dr. Fisher was also friendly and wrote Dr. Laughlin on October 3, 1952, extending "congratulations on your splendid effort."²⁰ Accordingly, the discourse was candid and useful, and many cogent points were covered.

Dr. Laughlin summarized the ideals and aims of the Academy Movement and the role and progress to date of the NCSPP. Dr. Fisher noted hazards in fostering

what might be a dissident group. This was countered with positive assurance implicit in the excellent caliber of those already interested. Dr. Merin expressed great enthusiasm about its prospects for success. Dr. Bieber was more reserved although he was clearly in favor of the prospective Academy goals and was glad to have them pursued by someone with energy and initiative. On the other hand, he doubted that the time was propitious, was reluctant to commit, and preferred to observe developments. He considered it wise to proceed "slowly and thus secure a broader base to the organization,"^{1,2,8,48} a view with which most pioneers were in substantial accord.

This meeting was quite useful and helped develop a more favorable climate within this important segment of New York analysts. Drs. Fisher and Merin inquired if help was needed with finances. The former, who had to leave prior to the meeting's adjournment, wrote shortly afterward²⁰ to comment that as a consequence of this occasion he had become more favorably disposed, "felt more encouraged about the broader purposes of the Academy," was pleased that Dr. Laughlin had "obtained more medical school adherents," and again proffered help in defraying expenses.

Drs. Fisher and Merin indicated by letter their feelings that Dr. Bieber was "too cautious,"⁴⁸ and as anticipated, he decided to "hold off sponsorship at this time,"⁸ later indicating "that some people such as me should be kept in reserve for another attempt should that become necessary." Nonetheless, Dr. Bieber was sincerely interested and later strongly supported the Academy Movement. He took an increasingly active and leading role in 1955 and afterward (p.715). These interests and activities progressed into his becoming the Academy's sixteenth president in 1971.

The interest of other members of the NYMC group was enlisted. Dr. Silverberg did not attend the meeting, but his influence noticeably hovered in the background when members of his group were involved. He received reports about the Move-

*In general, the
consensus of the four
people present was that
Dr. Laughlin should
proceed with his
endeavors and that he
would enjoy a
measure of
encouragement,
approval, and support.*

* Dr. Merin of New York City was a friend and colleague of Dr. Laughlin for years, later joining him again in the ACPsa. He became a founding fellow of the college (seniority number 33) on April 21, 1971. This was just prior to Dr. Masserman (on April 23, 1971), who had also been elected to fellowship the previous year in the ACP (seniority number 268) on March 6, 1970.

ment's progress and was kept apprised of developments. Dr. Bieber discussed various aspects with him from time to time,^{8,48} and he took an active part in the leadership in its closing phases. Dr. Silverberg proposed the enabling motion at the final organizational meetings in December 1955 and April 1956. This expressed the spirit of the Academy Movement and facilitated the fruition of its aims.

The William A. White Institute

An account of the significant role of Dr. Thompson* and a few of her colleagues in the W.A. White Institute of New York adds another interesting chapter to the history of the Academy Movement. Although at times behind the scenes, her position in the Movement was important, especially in the early and late phases of the overall gestation.

Dr. Thompson was a leading figure in psychoanalysis in America. She analyzed a number of those who became prominent analysts in America. From 1930 to 1932, she was the first president of the Washington-Baltimore Psychoanalytic Society, one of three original constituent societies in the APsA. She was an outstanding teacher with a special aptitude for clarifying complex psychoanalytic concepts. She wrote well, had many friends, and possessed an indomitable spirit, independence, and determination, which likely contributed to some of the professional struggles in which she became embroiled. She once aptly described herself as an "old warhorse."⁶⁹ Friendship with her antedated for some years the unveiling of the Academy concept,^{***} bringing her early into the picture in spring 1952 as with Dr. Martin,^{****} a natural consequence consistent with the philosophy of the Academy Movement.

Dr. Thompson was immediately interested and wanted to learn all about the Academy concept and planning. Close personal contact was maintained with her into the following year. She was thoroughly filled in on developments. Correspondence was frequent, and copies are extant of a score of letters exchanged, in addition to various personal meetings.

Not only was Dr. Thompson a source of encouragement during this crucial first

* Dr. Thompson was born on October 2, 1893 on the outskirts of Providence, Rhode Island. She graduated from Johns Hopkins Medical School in 1920 and completed a three-year residency at Phipps Clinic under Dr. Adolf Meyer in 1925, entering private practice in Baltimore that year.

She was a member of the Washington Psychoanalytic Association in the late twenties, presenting seven papers by 1930.³¹ While still a Baltimore resident, she was a founding member of the Washington-Baltimore Psychoanalytic Society (May 31, 1930), contributing to its organizational and scientific activities.⁵⁸ She was in Budapest for an analysis with Dr. Ferenczi, who was strongly recommended by Dr. Sullivan, during the summers of 1928⁷⁰ and 1929 and for two years subsequently (in June 1931 until Dr. Ferenczi's death in May 1933). Upon her return, she moved to New York City, continuing her teaching activities in Washington into the fifties.

** In fact, she had been through many organizational conflicts. She was 56 when she learned about the Academy Movement from Dr. Laughlin on May 9, 1952 in Atlantic City.

*** Dr. Thompson's professional activities shifted increasingly to New York from 1933 on, although her teaching in the Washington-Baltimore area continued into the 1950s, as noted. Dr. Crowley¹⁴ confirms that she became "a Training Analyst in the New York Psychoanalytic Institute in 1936, continuing until 1941 when she resigned because of Horney, and so had moved in 1933."

**** Dr. Martin was a longtime friend and APA associate of Dr. Laughlin with whom he later joined in the ACPsA, becoming a founding fellow (seniority number 30) January 19, 1971.

year, but her assistance also took more concrete forms. She evaluated the qualities of leaders, especially their personal attributes, professional attitudes, and potential value to the Movement for the NCSPP. In at least three letters she offered comments about her friend Dr. May E. Romm+ of Beverly Hills, who became a charter fellow and later a trustee. Dr. Thompson visited her in summer 1952. Over the months, she recommended various prospective supporters,⁶⁹ proffered advice, and generally cheered on Dr. Laughlin's endeavors.

From the beginning, Dr. Thompson was conversant with the ideals of the Academy and the importance of giving high priority to its scientific aspects, understood its goals of unifying the various groups, and was kept informed about the relationships being established with other independent groups. Slated before long with other W. A. White leaders, including Drs. Crowley, Rioch Bard, Spiegel,

Edward S. Taubert+, Wolberg, and Bryt, to assume leadership during the final organizational steps, Dr. Thompson practically had carte blanche access to the data and documents concerning the background, principles, and progress of the Academy Movement and the NCSPP, as well as names and varying levels of interest of people contacted.

From the beginning, Dr. Thompson was conversant with the ideals of the Academy and the importance of giving high priority to its scientific aspects, understood its goals of unifying the various groups, and was kept informed about the relationships being established with other independent groups.

In November, she asked for another copy of the *NCSPP Newsletter*,⁶⁹ which together with the Intergroup Conference protocol and the constitution, provided a complete summary and exposition of the Movement's significant aims and planning details. In addition to several of Dr. Laughlin's letters, these were shared with Drs. Crowley and Meyer H. Maskin+. Dr. Crowley, who first learned of Dr. Laughlin's work for the Academy through Dr. Thompson in 1952, in a direct exchange of letters,^{1,2,14,70} indicated to Dr. Laughlin in January 1953 the "tremendous lot of work already accomplished." In retrospect, it seems some W.A. White people had been informed in considerably less detail about the Academy Movement's accomplishments and the relationship between Drs. Thompson and Laughlin than the latter had every reason to believe.*

This early period was marked by Dr. Thompson's personal participation and support, which were greatly valued. She frequently reported the progress of her contacts and discussions on behalf of the Academy. Noteworthy examples were contacts with Drs. Romm and Fromm-Reichmann+ that helped enlist their interest and support. Additional interest and close contacts with W. A. White members were considered unnecessary in view of the excellent personal relationship with Dr. Thompson and were not actively pursued. Those existing contacts stemmed mainly from longstanding friendships, as with Drs. White and Bryt. Dr. Bryt, informed about the Academy Movement on May 9, 1952, also kept in touch with Dr. Merin.⁴⁸

* Also borne out by later reports.^{64,69} One W.A. White analyst wrote to Dr. Laughlin, "I had no idea the amount of careful arranging that went on. I had never heard of the NCSPP before. Nor was I aware of your role in the Movement." This he attributed to having been in a "peer group who were recent graduates of the White Institute, perhaps this is why we were not privy to what went on."² Dr. Laughlin had been assured that everyone at W.A. White, including students, were being informed of all developments.⁶⁹

As early as June 1952, Dr. Bryt¹¹ wrote to report that he had read the early correspondence between Drs. Thompson and Laughlin, and that the initial official W.A. White Institute leaders' reactions were less warm than what had been expressed. He added that while "your plan has received a cool reception [it has been] by no means a totally negative one," noting "your program is tremendously ambitious," and extended congratulations on the "very extensive steps that you have already taken."

On November 13, 1952, after four years* of disappointing attempts to secure APsaA approval, W.A. White leaders finally withdrew their application. A formal rejection was anticipated from an upcoming vote on their status by the Board on Professional Standards on December 7. This event was promptly reported to the NCSPP leadership by Dr. Thompson.⁶⁹

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In early December, there was a cordial dinner meeting in Washington between Drs. Thompson and Laughlin. Recent progress and prospects regarding the Academy were thoroughly reviewed. Rather than feeling defeated or dejected, Dr. Thompson was relieved,** almost in a mood to celebrate the end of a long unrewarding struggle. With some justification, she felt insufficiently supported, if not deserted, by colleagues, friends, and analysts—Drs. Hill*** (in analysis from 1929-39****), Hadley, and several other Washington-Baltimore colleagues with whom she had been long associated.

Her spirits were buoyant, however, and she was looking forward to the future with little bitterness about the long struggles and recent surrender. She expressed renewed enthusiasm about the Academy and sincere gratitude for Dr. Laughlin's spadework. As she recognized the full extent of the established interest and support, she was elated and considered imminent ways in which the W.A. White people could take a more active role. She found the prospects of their assuming leadership of the Movement which had been proffered by Dr. Laughlin, intriguing.

Preceding their next society meeting scheduled for December 11,

* Following a 1948 suggestion by the Washington-Baltimore Institute, which sponsored their psychoanalytic trainees, approval as a separate institute was applied for from the APsaA that year. In light of the 1946 reorganization and its effects, many painful and complex difficulties arose. These began almost immediately, and in late 1949, the Washington-Baltimore Institute dropped the W.A. White candidates from their roles. The following year, Drs. Thompson, Rioch Bard, and Crowley were dropped as training analysts by the Washington-Baltimore Institute, in line with a new APsaA geographic rule restricting training activities beyond a 50-mile radius—a move believed to be specifically directed against the W.A. White training program.

** Years later this was similarly described by Dr. Green,²² who wrote later in 1964 that she "seemed relieved when it was finally decided that there was no point in continuing to apply and the application was formally withdrawn."

*** A long-esteemed colleague and fine teacher until his death in 1958, Dr. Hill was director of the Washington-Baltimore Psychoanalytic Institute from 1940 to 1949. He was secretary of the APsaA in 1937 and president from 1940 to 1941. In 1948, when the W.A. White Institute needed endorsement for its application for approval from another institute, "Hill disqualified himself from giving an opinion."⁵⁸

**** Dr. Crowley¹⁴ adds, "To my certain knowledge Lewis was still [in analysis] with Clara as late as 1939; perhaps 1940. It was somewhere around 39/40 that Hill and Clara fell out...Lewis and I would ride the train together to NYC to see Clara, this from Baltimore in 1938-39."

Dr. Thompson wrote, "If we could take over the work on which you have already done so much, it would be a big help," adding, if "the time has come for us to take over, I think Ralph Crowley is the one to do it and he is respected by all."⁶⁹ He had actively participated in the affairs of several analytic societies and had years of training responsibilities in the Washington-Baltimore area and New York City.

Dr. Laughlin concurred and, after advising Dr. Fisher and other NCSPP leaders of the move, wrote to Dr. Crowley. But Dr. Crowley¹⁴ demurred when formally invited by Dr. Laughlin on January 2, 1953 to take over as the NCSPP secretary.

In 1953, however, Dr. Thompson again reversed her field. She decided it would be more politic to defer assuming leadership, reasoning her wish for the Academy's "charter membership to be exclusively members of the APsaA."⁶⁹ This stand was

shortly endorsed by Dr. Crowley** from W.A. White, who similarly commented that "such a group should start with members of the American [APsaA]." Maintained until its reversal two years later, the effect was antithetical to the Academy Movement, opposing its unique plans for unification and deferring speedier implementation of its goals.

The basis for various policies and policy changes by the leaders of the W.A. White Institute were undoubtedly closely related to their continuing vital struggles with the APsaA. These had become more acute following Dr. Sullivan's death in 1949. The struggles subsided somewhat after November 1952, following withdrawal of the earlier application for APsaA accreditation. But in 1954, these difficulties again became quite acute.

In any event, the W.A. White leaders' later reconsideration to go along with the original principles were very important. This was an essential step in paving the way for their assumption of leadership in the Academy Movement, making possible the final steps in organization.

The implementation of the original principles vindicated Dr. Laughlin's ideas, which had been shared by a fair number of interested friends and colleagues.

Dr. Thompson was of great assistance during a crucial period in promoting the Academy Movement and in launching the NCSPP as its predecessor and sponsoring body. With other leaders of the W.A. White group, she later also played a significant role in the final chapter of the Academy's founding.

The basis for various policies and policy changes by the leaders of the W.A. White Institute were undoubtedly closely related to their continuing vital struggles with the APsaA

* Accordingly, Dr. Thompson wrote,⁶⁹ "My decision is not to go along at this time [although] I admire your personal enthusiasm and the great amount of energy you have put into this." Dr. Rioch Bard, first president of the Academy, did not agree with having APsaA membership as a requirement.⁶⁴ At this time, nine W.A. White faculty members were also APsaA members.

** Dr. Crowley wrote in 1970,¹⁴ "I too had become convinced that we should start with members of the [APsaA], along with Clara, and since I felt I could not go along with your plans I refused the [NCSPP] Secretaryship." He turned down the proffered post in a letter dated January 9, 1953.

Dr. Crowley had an interest in psychoanalytic history, contributing to the Noble-Burnham account of the Washington Society,⁵⁸ and on several occasions, checking data on which the present account is based.¹⁴ In May 1967, he also passed along copies of some of Dr. Laughlin's earlier correspondence regarding the Movement to Academy historian Dr. Millet.^{1,2,14,56}

Endeavors Contribute to the Academy Movement

A Provisional Constitution

Various endeavors were involved in furthering the Academy Movement in its early years. These included preparing a provisional constitution for the proposed Academy, planning an intergroup conference on psychoanalysis, creating the NCSPP, and maintaining extensive correspondence and meetings with leaders in the field.

A constitution embodying the general principles and philosophy of the prospective Academy was developed through several drafts beginning in early spring 1952.¹ The resulting document was circulated for review to enlist interest and for informational purposes. Robert L. Robinson,⁶⁵ press officer of the American Psychiatric Association (APA) and an expert on organizational matters, reviewed it. Several pioneers used this document to encourage interest and support.

A constitution embodying the general principles and philosophy of the prospective Academy was developed through several drafts beginning in early spring 1952.

Records indicate that early copies of this constitution were furnished upon request to Drs. Joseph H. Merin, August 19, 1952; Heath and Monroe,* August 18, 1952; and Bieber and Fisher, September 21, 1952. Dr. Jules H. Masserman** was sent an original copy on September 15, 1952, and another on May 11, 1955. Dr. Wolberg received his from Dr. Merin on May 16, 1955.⁴⁸

The constitution was an eight-page document. The original draft was completed by May 1952, revised in August of that year, and revised again in May 1954. During September 1952, NCSPP members Drs. Laughlin, Masserman, and Merin reviewed, studied, and signed the document, formally indicating "their approval and acceptance of this Constitution and By-Laws and their support and sponsorship of the American Academy of Psychoanalysis."

Circulation of the constitution was very useful, and a number of helpful comments, changes, and editorial recommendations were made. The more detailed refinements came from Drs. Merin⁴⁸ on September 8, 1952, Monroe⁵³ on October 13, 1952, and Lussheimer⁴² on January 10, 1953. For example, an early inclusion was a provision (Article X, Section 4) designed to foster the establishment of an "American Board of Psychoanalysis." This was later deleted at Dr. Masserman's recommendation.***

There were provisions for active, associate, and honorary members, and for affiliate membership for dynamically oriented scientific associates. Procedures

* Dr. Monroe, later of Baltimore, was again an organizational colleague on March 20, 1971, when he was elected a fellow in the ACP (seniority number 345).

** This is of special interest in view of Dr. Masserman's later involvement with drafting the final version of the Academy's constitution.

*** He feared that including this provision would unduly invite hostile attention from the APsAA hierarchy and might even lead to its preemption. There was a great deal of dialogue a few years later concerning possible board certification in psychoanalysis between the APsAA, the Academy, and the American Board of Psychiatry and Neurology.^{47,51}

were outlined for committees, elections, officers, amendments, and democratic governing. While the constitution, finally adopted in Chicago in 1956, differed in format, the main concepts and philosophy embodied in its predecessor were well reflected.* There is little question that the circulation of information while developing the prototype document helped advance the Academy Movement.

The Washington Intergroup Conference on Psychoanalysis

The conference was planned for June 21–22, 1952. A protocol was drawn up, and areas for discussion were outlined. Speakers and discussants were invited and scheduled. An agenda was forwarded to the first score of probable attendees.¹

This material outlined the concept of an American Academy of Psychoanalysis. Even at this early stage, the organizational concept was carefully outlined, published, and referred to by name. Additional areas scheduled for discussion at the Intergroup Conference included

1. The place of psychoanalysis in medicine
2. Trends in psychoanalytic training
3. Organization

Overall, the conference elicited much interest. However, the June dates conflicted with vacation schedules and other commitments. More seriously, the outbreak of the Korean War made conditions uncertain for many people. Some were understandably reluctant to make firm plans or commitments.

Finally, when two major participants became ill, the effects of these negative factors on attendance were too great and the conference was called off, even though many people had originally planned to attend. Although abortive, the endeavor was constructive. There was wide dissemination of information, personal and professional contacts, interest arousal, and beneficial effects resulting from the mobilization of favorable sentiment for the Academy.

Among the analytic leaders who planned to participate, Dr. Ham of Chapel Hill,** who had recently come from Chicago to head the psychiatry department at the University of North Carolina, and Dr. Merin were scheduled to open the

* Dr. Masserman reports that he and Dr. Henry A. Davidson "completed a draft in an hour" at the Chicago meeting in May 1956, which was adopted "with only minor changes." This is not too remarkable since he was most conversant with the provisional constitution, next to its author. It is hardly surprising that the philosophy and provisions of this predecessor document are prominent in the final constitution of the Academy.

Dr. Spiegel, chairperson of the Constitution Committee from 1955 to 1956, takes some exception to this abbreviated account, noting preliminary work in New York, with "details relating to policies to be filled in at Chicago. At the Chicago meeting, I was the chairperson of this part of the meeting to fill in the boxes of the Constitution, and part way through this, Masserman took over to speed up the procedure."⁶⁸ Dr. Spiegel of New York City was later elected to fellowship in the ACP in Washington, DC (seniority number 416) on October 13, 1973. He accepted on October 24.

** Dr. Ham (seniority number 7), NCSPP, continued collaborating with Dr. Laughlin. He participated as a charter fellow (seniority number 65) April 20, 1972 in the ACPsa. He died on September 26, 1977.

discussion on two of the four major topics: Dr. Merin to keynote Section I; Dr. Ham, Section III.

Dr. Heath of New Orleans, originally from the Columbia group and an original Academy trustee (1956-58), was also contacted at this time. He was recommended by Dr. Blain, medical director of the APA. Although Dr. Blain's position precluded further participation, his interest and advice were helpful on several occasions. Dr. Heath was informed about the Movement by Dr. Laughlin's letter of June 3, 1952, inviting his participation in the Intergroup Conference. This followed Dr. Blain's endorsement, with a second recommendation from Dr. Ham²⁴ on May 27, 1952.

On September 30, 1952, Dr. Heath²⁵ nominated Dr. Monroe, (who sent that fall a thoughtful critique of the Academy concept and of the *NCSPP Newsletter*) to represent the Tulane University department faculty "in all matters relating to the Academy."¹ Dr. Douglas S. Bond, head of the psychiatric department at Cleveland, arranged in May for Dr. John M. Flumerfelt to be the department's representative at the Intergroup Conference.* Drs. Merin, Fisher (who later volunteered funds on two occasions),²⁰ and Bieber planned to participate from the New York Society for Medical Psychoanalysis. A number of other prominent people, including Dr. Lawrence C. Kolb³² of the Mayo Clinic, indicated interest, suggested possible recruits, and contributed helpful comments. Dr. Masserman, who was contacted at this time (at the suggestion of Dr. Thompson) following his receipt of the initial correspondence concerning the Intergroup Conference, dated June 2, 1952, indicated his interest although he was unable to attend. Dr. Zuger from the AAP^{48,75} planned to attend and regretted the cancellation.

On behalf of the W.A. White group, Dr. Thompson⁶⁹ advised on May 26 that they would be represented** by Drs. Rioch Bard and Bryt. Another dozen or so analysts from the Washington area and representatives from six or seven other centers planned to attend. Everyone was understandably disappointed when cancellation of the Washington Intergroup Conference became unavoidable.

*Everyone was
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unavoidable.*

* A long-term friend, Dr. Bond continued his close association with Dr. Laughlin until Dr. Bond's death on October 9, 1976. On March 10, 1965, he was elected charter fellow (seniority number 84) of the ACP and a founding fellow of the ACPsa on October 30, 1970 (seniority number 25), of which he became president, 1975-76.

** Dr. Thompson could not come "because I shall be on my way to Los Angeles." On this trip, she visited Dr. Romm, an old respected friend and confidant, with whom she again discussed the Academy plans, prior to going to her summer home at 599 Commercial Street, Provincetown, Massachusetts, on July 9, as was her usual custom. They traveled to New York together by train after the Atlantic City meetings. During their trip, Dr. Thompson reported, "I told her your plans," and described her favorable reaction. This was accompanied by an expression of continuing hope for meaningful reforms from within the APsaA by the end of the year.

The National Committee for Scientific Progress in Psychoanalysis

Interim Organization Created

During the course of fostering the Academy Movement, a need became discernible for some form of group identification. This would be useful for leaders who were more firmly committed to the concept and were working closely on its behalf. A suitable collective name would also be convenient for referring to the group and its members.

The National Committee for Scientific Progress in Psychoanalysis (NCSPP) was created in summer 1952.⁵⁶ Gradually, a small coterie of people provided invaluable support. Dr. Saul,⁶⁷ for example, wrote on November 1, 1952, to indicate his interest and agreement with the ten basic principles of the Academy.

Besides practical advantages, the purposes of the NCSPP included active encouragement of the Academy Movement, as well as serving as an interim predecessor pending final organization of the Academy. As planned, having the NCSPP was an advantage to the pioneers and their Movement. It functioned usefully in its intended capacities for several years.

A number of psychoanalytic leaders contributed interest or support in varying measures during the crucial early days of 1952. Fourteen of these leaders had already become NCSPP members by early the following year. As significant contributors to the Academy Movement with a few others, they can be regarded as the founding fathers of the Academy.

An early seniority roster, in which the first NCSPP members were listed with dates according to their time of invitation and inclusion, is as follows:

Table

The National Committee For Scientific Progress in Psychoanalysis

An interim group helping to mobilize sentiment, and serving as a predecessor for the American Academy of Psychoanalysis:

Seniority Roster—February 15, 1953

1. Dr. Henry P. Laughlin, Chairperson and Treasurer, Washington, 1950-52
2. Dr. Jules H. Masserman, Chicago, 9/15/52
3. Dr. Joseph H. Merin, New York City, 9/20/52
4. Dr. Russell R. Monroe, New Orleans, 9/23/52
5. Dr. Lester L. Burtnick, Washington, 9/24/52
6. Dr. Harry H. Garner, Chicago, 10/29/52
7. Dr. George C. Ham, Chapel Hill, 10/30/52
8. Dr. Leon J. Saul, Philadelphia, 11/15/52
9. Dr. Alexander Reid Martin, New York, 11/16/52
10. Dr. Paul Lussheimer, New York City, 11/24/52
11. Dr. Saul H. Fisher, New York City, 12/10/52
12. Dr. Bernard A. Cruvant, Washington, 12/12/52
13. Dr. Bernard Zuger, New York City, 12/30/52
14. Dr. Wanda Willig, New York City, 1/10/53

When evaluating the NCSPP's role, it is clear that the members of this group merit recognition and commendation for their confidence, courage, determination, and commitment to an idea at a time when it promised little in return. Backing a movement with an uncertain future could prove unrewarding, if not professionally hazardous.

Interest and support for the Academy Movement from 1952 to 1955 was not confined to this small band of committed compatriots. There were various indications of interest from many people. Contacts and informational exchange were gradually undertaken in widespread fashion. The result was a steady accretion of favorable sentiment throughout an appreciable segment of the profession.

An extensive correspondence was involved in conducting NCSPP and Academy business. Appropriate stationery was designed and used by several NCSPP mem-

bers, including Drs. Masserman and Merin. The availability of second sheets facilitated the preservation of copies of letters. For a brief period from May 29, 1952, there was a part-time volunteer administrative secretary, Alice Mason D'Amore of Washington. Otherwise, all work was done by Dr. Laughlin.

A fair amount was accomplished by the NCSPP pioneers and their colleagues in preparing ground for the Academy. In conclusion, an assessment of the NCSPP's endeavors indicates a substantial contribution to the Academy Movement and eventual implementation of its goals.

The NCSPP Newsletter

The *NCSPP Newsletter* was prepared through a number of drafts, beginning in July 1952. An eight-page edition was circulated over the following year. Its five-person editorial board⁵⁶ was comprised of Drs. Ham,²⁴ appointed on October 30, 1952; Garner,²¹ November 15, 1952; Laughlin, July 5, 1952; Martin,⁴⁵ November 16, 1952; and Masserman,⁴⁶ October 22, 1952. Dr. Bieber⁸ declined membership in late October, as did Dr. Heath²⁵ for family reasons the following month. Dr. Heath, however, wanted later consideration.

The newsletter described the NCSPP and outlined the ideals and principles of the Academy Movement. The establishment of the American Academy of Psychoanalysis was proposed and its goals described as assessed by an NCSPP colleague in October 1952. Items from NCSPP correspondence were selectively quoted, the NCSPP and its predecessor role were discussed, and information about the Intergroup Conference and its cancellation were reported. Section V listed the so-called cardinal points* that would help establish the "milieu best suited to better scientific progress in psychoanalysis...through the establishment of the American Academy of Psychoanalysis."⁵⁶

Many read and reviewed the newsletter, and it was the basis for several

When evaluating the NCSPP's role, it is clear that the members of this group merit recognition and commendation for their confidence, courage, determination, and commitment to an idea at a time when it promised little in return.

* Stated as a matter of policy, "the newsletter firmly advocates the ten cardinal points, to which the Academy will be dedicated." These summarized the purposes and goals outlined earlier.

presentations to analytic groups. Dr. Thompson⁶⁹ reported bringing some of the material "before the members of our Society" at a December 1952 meeting. Dr. Fisher²⁰ wrote to say he was "wholeheartedly in agreement with the contents of this newsletter," and kindly offered "any help you may need in what must be a very time-consuming task."

Existing records document at least two dozen persons who were provided copies,* to which most offered comments. In fact, its circulation was more widespread as some shared copies with others.^{1,2,11,14,42,69} It was read by a number of Academy people, and this modest publication might be viewed as the prototype first edition of *The Academy*, the present Academy newsletter,** pushing its founding date back five years. The overall effects of the newsletter were positive. It promoted favorable sentiment for the Academy, generally improving the professional climate and its receptivity.

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Organizational Challenges

Continuing Needs. Fostered by the NCSPP and its professional allies, the Academy Movement moved forward. Dr. Laughlin and others experienced satisfaction in observing its progress and pleasure in participating in a significant endeavor. Dr. Lussheimer's recollections⁴² confirm this. On the other hand, there were many challenges and problems needing resolution from administrative and organizational standpoints. Concerning possible functions of training, Drs. Franz Alexander and Saul represented diametrically opposed points of view, which had to be reconciled. The hesitant required encouragement, misgivings had to be allayed, and decisions had to be made. These were important continuing needs.

Recruiting new people was an ongoing requirement, and adherents needed continuing contacts and communication. A running correspondence with a number of people had to be maintained. As a position of more widespread interest was achieved, the acuteness of these needs decreased.

Unification. Another challenge was the unique and constructive goal of national unification of members of various psychoanalytic groups.

The successful promulgation of this feature required the utmost diplomacy. Several people in each group were lukewarm to the concept, if not in strong

* These were Drs. Alexander, Bieber, Bond, Bryt, Burtneck, Crowley (eleventh president), Cruvant, Fisher, Garner, Heath, Horney, Levine, Lussheimer, Martin, Masserman, Merin, Monroe, Romm, Ruffin, Saul, Thompson, Willig, and Zuger. Other recipients were not specifically recorded.

** Originated in 1957, "initially the newsletter was supposed to inform the members of the activities of the officers and the Executive Committee." Dr. Mumford⁵⁵ writes, "In those years it fell short of that goal. Still, it served a useful purpose and was fun to work with." Dr. Milton Mazer was the first editor, and Dr. Mumford succeeded him, serving from 1959 to 1961. This useful publication further evolved and was renamed *The Academy*.

opposition. This goal also occasioned the comment to Laughlin about the program being "tremendously ambitious."

Many positive values had been envisioned in seeking to unify the liberal, democratic, and independent forces in psychoanalysis. Advantages included increased strength, greater understanding, less theoretical divergence, promotion of personal and professional relationships, enhanced contributions to scientific progress, and an improvement in the overall stature of the field. This may explain why the idea of union had high priority from the beginning. However, it is evident there were major crosscurrents concerning this goal, and all were not equally committed.

As the originator of the concept and initiator of the Movement, Dr. Laughlin immediately tackled the mobilization of favorable sentiment toward this goal. He acquainted various leaders with the Academy Movement's basic ideals and aims to persuade them of their validity and build a sound base for the organization he had conceived.

Drs. Martin,⁴⁵ Merin,⁴⁸ Lussheimer,⁴² Zuger,⁷⁵ and other pioneers⁵⁶ had considerable enthusiasm about the goal of unification. They saw great value in various groups acting in closer concert in scientific and organizational pursuits. A liberal, national, professional organization, in which psychoanalysts from all groups could participate, would benefit everyone. However, this goal was less meaningful for some, and as noted, it was seriously impeded for several years through the adamant opposition and official policy of the leaders of one major independent group.

The reconciliation of differences over the unification goal was a major administrative and organizational challenge, but it was a hurdle that was met squarely, resolutely, and unwaveringly, and was eventually achieved. For more than a decade, this seemed such an insurmountable obstacle that several critics of the Movement ridiculed it and even relied heavily on this barrier to prevent the Academy Movement from coming to fruition. Reaching this goal was a major achievement.

Crosscurrents. Additional aims held high priority for some analysts, while holding little priority for others. For example, not denigrating other worthwhile NCSPP goals, Dr. Saul⁶⁷ strongly stressed that while "a good forum is a fine thing, the crying need nationally is for good training and this is the real challenge to the Academy, which I hope will not long delay in meeting it."

The respective value of various aims of the Academy Movement varied in the view of its participants. Likewise, the resulting organization people wanted or expected varied, sometimes widely. Some differences have been noted. Some wanted a group oriented primarily toward the conferring of prestige and status*—

* This function was admirably served in due course by the ACPsa. This type of organization, while significant at the proper time and in the proper sequence, would have been premature during this period and not in accord with Dr. Laughlin's long-range organizational plans. Getting the Academy successfully underway and establishing its position was a prerequisite to the founding of the college. Any unveiling of these ambitious plans in the early fifties might have been viewed as grandiosity.

The reconciliation of differences over the unification goal was a major administrative and organizational challenge, but it was a hurdle that was met squarely, resolutely, unwaveringly, and was eventually achieved.

an honorary organization. Others were more interested in promoting its scientific and functional aspects. While these aims were not necessarily incompatible, the possibility of their becoming alternative pathways posed problems for some. Each issue contributed to crosscurrents of opinion and viewpoints among the Academy's supporters.

In another direction, Dr. Monroe⁵³ recalls "strong feelings at Tulane, Columbia, and other places that the membership of the Academy should be limited to institutes in association with hospitals or medical schools...." Physicians were convinced that this was going to be the future trend of psychoanalytic growth and progress. Some analysts were strongly opposed to their inclusion in the Academy or to the psychoanalytic training of nonphysicians.* Others, citing the example of the gifted psychologist and author Dr. Erich A. Fromm, wanted the door open.

It was not always possible to fully reconcile such widely divergent interests.

This was despite the fact, as one leader observed, that "a great amount of careful diplomatic arranging went on."² When a real impasse was reached, the Movement risked losing a potential supporter, as happened with Dr. Levy.**

...many immediately indicated a desire to be kept informed of all developments regarding the NCSPP and its work on behalf of the Academy. However, there was often no real commitment, and not all were desirous of actively participating.

Commitment Level Variable. From the outset, nearly everyone contacted on behalf of the Academy was interested. Of those, many immediately indicated a desire to be kept informed of all developments regarding the NCSPP and its work on behalf of the Academy. However, there was often no real commitment, and not all were desirous of actively participating.

A certain amount of misgiving and hesitation was understandable, especially in the early days. During this period, certain prominent psychoanalysts, such as Drs. Bieber and Kelman⁷⁵ (thirteenth president of the Academy), were cautious and hesitant, and questioned whether the time was ripe for fostering the Academy concept, joining the NCSPP, or actively supporting the Movement. As the Movement gained momentum and prospects grew brighter, these two leaders took increasingly active roles. Still, a fair number felt safer, less threatened, and content to hold off, avoid risks, and adopt a wait-and-see attitude. A few analysts never affiliated with the Academy even after the risks had dissipated, the basic

* This issue continued. The W.A. White Institute continued this practice, although not all of its people were in accord. For instance, in early 1956 a petition was written and circulated that strongly urged "the Fellows of the Institute to stop training psychologists as equivalents...However, the resolution which was signed by 44 physicians was rejected by the Fellows."²

This same issue caused problems earlier in the United States—for example, entering into the 1941 split of the AAP. The revocation of Dr. Fromm's training position was a crucial issue here. ** Dr. Lief⁴¹ later cited "the training of lay analysts by the White Institute" as the reason that Dr. Levy of the Psychoanalytic Clinic for Training and Research "did not follow through and become a member of the Academy," although a number of founders long desired his affiliation. He participated in an important preliminary organization meeting in New York City in December 1955.

concepts were implemented successfully, and the Academy was duly established with a position of substantial strength.

The level of commitment varied widely. This inevitably resulted in more responsibility falling on the founding fathers, especially during the first years of the Movement. The basis for these overly cautious attitudes is difficult for some people to appreciate today. They were real enough in the decade following 1950, especially to the people who had started the game and to those carrying the ball.

Motivation and Leadership. Questions raised about leaders of the Movement seeking personal glory were hardly valid. In the early phases, it was an idealistically motivated endeavor that required hard work. Many disappointments and frustrations counterbalanced the gratification of occasional success. As noted, the founder proposed turning over his role to others several times—proposals which were declined by Drs. Masserman, Merin, and Crowley.

Drs. Bieber, Martin, Alexander, Horney, Silverberg, Saul, and Fromm-Reichmann were content to retain minor roles, although each was urged to take more active positions of leadership in the Academy Movement. When pressed to spark the final drive from Chicago in mid-1955, Dr. Masserman was again reluctant.

Dr. Thompson, a longtime veteran of many organizational conflicts, remained in the background during 1953-55. Her only official position was as one of the original group of elected trustees, during 1956-57. In distinction from other founders who were less fortunate (p.726), she lived long enough to actively participate in the successful culmination of the Movement.

Finances. With no ready source of funds, the finances of the Academy Movement and the NCSPP were chaotic. Except for small unsolicited contributions from Dr. Merin on November 25, 1952, Dr. Masserman on November 30, 1952, and several others, costs were absorbed by the Movement's founder, as was reported to Dr. Fisher in 1953.¹

In accord with Dr. Masserman's proposal⁴⁶ on November 18, 1952, Dr. Laughlin acted as treasurer. Looking ahead, Dr. Laughlin planned to continue assistance through the assignment of a share of the royalties from his books* to be published, as was accomplished with several other professional groups.

* Textbooks published in due course were *The Neuroses in Clinical Practice*, Philadelphia and London: W.B. Saunders, 1956 and *Mental Mechanisms*, Washington, DC, London and Sydney: Butterworths 1963. Their publication required more time than anticipated, and by the time royalty income was forthcoming, the financial needs of the Academy seemed less urgent.

Later works included *The Neuroses*, Washington, London, Toronto, Sydney, and Woburn: Butterworths, 1967; New York: Appleton-Century-Crofts, 1970 and 1986; *Psychotherapy and Behavioral Sciences Book Club* main selection, 1970. *The Ego and Its Defenses*, New York: Appleton-Century-Crofts, 1970-1977; *Behavioral Science Book Service* selection, 1973-74; Second Edition, New York and London: Jason Aronson, 1979; Main selection of the *Psychotherapy and Social Sciences Book Club*, July 1979.

The royalties from these works, which achieved the status of best sellers in the medical book world, have been subsequently assigned, as long planned, among a number of worthwhile professional organizations.

A Minor Miracle. It proved possible to reconcile many major differences of a significant group of fine and talented people. Even at this later date, this achievement seems like a minor modern miracle. The ideals and aims of the Academy had been clearly and repeatedly outlined. They offered sufficient value to a wide group of leaders in American psychoanalysis.

The successful establishment of the American Academy of Psychoanalysis proved to be a feasible goal. This had been long anticipated by the founding fathers and their loyal band of associates.

Opposition

Misunderstandings Contribute. There is a less felicitous side to the Academy story that should receive mention. Some in the field of psychoanalysis were less than delighted with the Academy's ideals and sometimes took a dim view of the Movement and those responsible for its promotion. This type of reaction was far more manifest and openly expressed in the earlier days. Some endeavors occasioned less than friendly regard.

A number of misunderstandings contributed to the generation of hostile feelings toward the pioneers responsible for fostering the Movement.

A number of misunderstandings contributed to the generation of hostile feelings toward the pioneers responsible for fostering the Movement. At times, it seemed that some opponents did not want these cleared up. One case involved the presumed issue of training. From the time of its conception, the Academy Movement and nearly all involved had no intention that the new organization would undertake functions of training or determining qualifications in psychoanalysis. These aims were specifically renounced. Nevertheless, this was not clearly understood and some in the APsA hierarchy experienced this as a threat.

Dr. Saul⁶⁷ noted, "Alexander was strong in his opinion on this and would have refused to consider the Academy if it had anything to do with training." Only a small handful shared Dr. Saul's view of "training as the key to the health of psychoanalysis" and wanted training to be an integral part of the program.

Idealists vs Rebels. During this decade, perhaps any professional development that held clear prospects for change in the national organizational status quo would have been viewed by more conservative analysts as threatening. However, the Academy was never intended to rival the APsA, nor was there ever any intent to try to usurp its prerogatives.⁵²

The purpose of the Academy was to serve long-needed liberal and constructive functions in psychoanalysis for that segment of analysts who were so inclined.* These functions afforded distinct advantages to the liberal elements of the field, which the senior organization would not and could not provide. These included

* Constructive and liberalizing organizational effects on the APsA were envisaged independently by the Movement's founder and other analysts. Dr. Millet stated,⁴⁹ "I shared with Franz Alexander, that the Academy could well serve the American [Psychoanalytic Association] in the same way and to the same effect as that exercised by GAP [Group for the Advancement of Psychiatry] on the structure, functions and aims of the APA. It seems to me that if the Academy never contributed anything more than this to the history of scientific and human thinking in our field it would have justified its existence."

bringing together on a national level excellent forces, many of which had departed the fold but survived and prospered. Since the APsaA made it abundantly clear that these had been disowned, and it had not the faintest interest in their present or future affiliation, nothing was being taken away.

While the founders might have been labeled idealists, these pioneers were sometimes considered rebels. One leading analyst flatly accused them of "declaring war on the APsaA." Although this was not true, endeavors on behalf of the Academy Movement were at times misinterpreted as being directed with hostile intent against the senior group.

Warning Conveyed. While the opposition's more outspoken critics were not terribly numerous, they were not necessarily gentle. This is pointedly illustrated in one poignant vignette in which a sober warning was conveyed by a nationally prominent colleague. He was a leading officer in the APsaA, belonging to its inner circles and hierarchy. This longtime friend warned the founder that should he persist in fostering his Academy concept, it would lead to professional sanctions, loss of status, and alienation of friends and professional colleagues, and it would irreparably damage his prestige and practice.

There was no question about the seriousness of the warning nor of the person* who conveyed it. However, to whatever extent these personal and professional injuries were suffered, the ultimately successful implementation of Dr. Laughlin's plans provided personal satisfaction as some measure of compensation.

APsaA Expulsion Potential. Potential supporters of the Movement were certain of similar resulting hostile reactions from colleagues and the APsaA hierarchy. The potential of expulsion from the APsaA constituted a realistic and potent threat for some. This was never carried out** but was attempted, as we will see later. In retrospect, this would seem unlikely. It would undoubtedly have been organizationally self-defeating since it would have resulted in the loss of more people by the APsaA, provided critics of the senior group with added ammunition, and perhaps alienated more able analysts.

As it became apparent that such action was doubtful and would not be taken, more senior people and their younger colleagues followed their real inclinations.

* Dr. Morse made these comments in February 1954. He was certain the Academy could not succeed in any event. Since the Academy concept would most certainly fail, the NCSPP and the entire Academy Movement was doomed to become a lost cause, with the inevitable professional and psychological repercussions of this on the founder and his fellow pioneers.

Despite Dr. Morse's opposition (he had helped crew the *Corysant* on the July cruise in 1952) and the warning he conveyed, he remained a close friend to the last day of his life. This was not true for all, however, and injuries were suffered.

While Dr. Morse's prediction was proven incorrect, his warning was to an extent correct, and there were indeed inimical consequences in the directions he anticipated. Experienced over subsequent years, a few were overt, but more often they were of a more subtle character.

** As might have been anticipated, this particular hazard sometimes had reversed effects a few years later, after the Academy became firmly established and provided a viable and worthwhile second national organization in American psychoanalysis. Its existence could even provide a form of insurance. Dr. Bullard¹² invited attention to this particular motive entering into the basis for certain colleagues' later affiliations with the Academy. He recalled how his decision to join was positively influenced by an episode in which his position in the APsaA was threatened.

These analysts came to side with the ideals, aims, and goals of the Movement, and later affiliated with the American Academy of Psychoanalysis.

Academy Movement Continues Progress

Evaluations Helpful. Through careful recruitment, more psychoanalysts allied with the Movement. Dr. Saul, nationally prominent in the field as a clinician, teacher, author, and later a trustee* (1958-61), first offered assistance in October 1952 when he suggested the names of possible recruits and proffered advice. The following month, he stated⁶⁷ that he was "all with it, and would help on policy if you want." Still later, he wrote, "As you know, my interest in the Academy has been a long and sustained one and I am doing what I can to further its goals." Dr. Saul had been an old friend and fellow officer in the U.S. Navy Medical Corps throughout WWII. His interest and aid were most welcome.

Evaluations of various leaders were provided by NCSPP colleagues and other supporters.

These were often refreshingly frank and proved quite helpful...

Drs. Thompson, Merin, Masserman, Martin, Lussheimer, and a wide circle of colleagues recommended people as potential proponents. Evaluations of various leaders were provided by NCSPP colleagues and other supporters. These were often refreshingly frank and proved quite helpful, but in view of their confidential nature had best remain private at least for a few years more. In a similar vein, Dr. Grinker²³ advised some years ago (1958) that "the time is not yet right for publication of this history." This was a correct assessment at that time, far more so than today. Since personal data comprise a significant segment of this history, this may be apparent to the reader. Later, on different grounds, he preferred not including "so many names."² This was an inevitable consequence of seeking to provide an accurate chronicle with reasonable detail of the sequence of events, to record the names of the pioneers, and to cite the proper places and dates. It also reflected efforts to properly credit valued contributors. Dr. Martin⁴⁵ wrote, "You have leaned over backwards in trying to be fair to the Founding Fathers." As with a number of similar comments,** this evaluation was much appreciated.

Mobilizing Sentiment. As time passed, progress continued. Letters were written, calls made, and conferences held at various times and places. Examples

* As another indication of the esteem long accorded him, as far back as November 1952, Dr. Saul was mentioned by Drs. Masserman and Laughlin as an excellent possibility for becoming the Academy's first president.^{1,46} Although this would have comprised a well-merited recognition, Dr. Saul did not have the honor of serving as president of the Academy. An early member of the NCSPP, Dr. Saul continued his support of the Movement founder's organizational endeavors. He was elected fellow of the ACP (seniority number 382) March 21, 1972, and became a founding fellow of the ACPsa (seniority number 16) April 10, 1970. Dr. Saul's death on May 30, 1975, was a loss to the entire profession.

** Many of the reviewers of this document agree with one strong exception. A distinguished past president of the Academy stated, "The role of Sandor Rado has been slighted in the manuscript. He played a very dominating role right from the very beginning and only the fear of some people that some of his personal idiosyncrasies might harm the Academy during its inception prevented his being elected president during the first several years."²

Dr. Rado was a distinguished teacher, author, and leader in American psychoanalysis for many years.^{60,61,62,63} He became the seventh president of the Academy in 1962.

of earlier interesting meetings have been cited. Some important preliminary meetings worthy of recording include those held with Dr. Masserman in St. Louis in May 1954 and the following year at the annual psychiatric and psychoanalytic meetings in Atlantic City. Dr. Laughlin also met there and in Washington, DC, with Dr. Thompson, with Dr. Lussheimer in New York City, Dr. Ham in White Sulphur Springs, Dr. Saul in Atlantic City, and Dr. Merin and others in Chicago, St. Louis, Atlantic City, and New York.

The NCSPP continued to function effectively for an optimal period, during which time the group, its identity, and name proved quite useful for purposes of communication, identification, and reference. It also subserved its major purpose in helping to mobilize sentiment on a widening base, benefiting the Academy cause.⁵⁶ Over the course of the next two years, more psychoanalysts became convinced of the value and feasibility of the Movement's principles and grew increasingly receptive to the Academy's establishment.

NCSPP Functions Subserved. Fostering the growth of this favorable professional climate was the primary function of the NCSPP. As this was secured, the inclusion of new people was less important. Its second and subsidiary function as an interim precursor organization for the Academy also became less necessary as its basic goals were achieved. Its activities were phased out as additional initiative and leadership were developed. In reaching the point where the pace of progress was quickening, the NCSPP had well subserved its functions.

The Academy concept was evolved with care and deliberation. Following this phase it was painstakingly evaluated and pursued with dedication. The successful establishment of the Academy became a matter of increasing imminence. The goals of the Academy Movement were carefully fostered and their implementation was facilitated. The stature of the organization that subsequently resulted was enhanced and its future progress more assured.

The Pace Quickens

Additional Leadership Gained

Atlantic City Meetings. By 1955, further significant meetings were held. Drs. Masserman, Spiegel, Thompson, and Wolberg⁷⁴ (who arranged the occasion and reports having discussed the Movement with Dr. Masserman a year earlier in 1954) met to discuss the Academy in May 1955. Dr. Wolberg, a leading author, clinician, and teacher, wanted "a new analytic society which would embrace extensions from classical theory and method." He had been analyzed by Dr. Thompson in New York, as had Drs. Hill (1929-39), Sullivan (1933-35), and Crowley (1938-42). When Dr. Wolberg talked with Dr. Masserman in 1954, Dr. Laughlin's endeavors were mentioned. At this meeting, various procedural matters were discussed.

Certain advantages were noted in having the impetus for the Academy emanate in greater measure from another section of the country.

These included provision for membership of graduates of all psychoanalytic institutes and superior professional standing for members of the organizing group. Certain advantages were noted in having the impetus for the Academy emanate in greater measure from another section of the country. This was in distinction from having it come exclusively from Washington and the Atlantic seaboard, as had been the case to that point. Dr. Masserman was urged by colleagues to take a more prominent role in recruiting. Some colleagues were still being hesitant and overly cautious.

Conferring again with Dr. Laughlin, who furnished him with another copy of the provisional constitution, Dr. Masserman expressed renewed enthusiasm and optimism for the Movement. Dr. Laughlin met individually with Drs. Bryt, Martin, Merin, Zuger, and others who were attending the annual meetings being held in Atlantic City in May 1955. The Academy Movement was increasing in momentum.

New York Meetings. Later that same month, Drs. Merin⁴⁸ and Robert S. Mumford⁵⁵ met in New York with Drs. Spiegel, Wolberg, and Miltiades L. Zaphiropoulos+ to discuss progress and resolve views on the makeup of the final organizing group. The pace was quickening.

On May 22, 1955, Drs. Bieber, Crowley, Silverberg, Thompson, and Wolberg met, again covering various organizational matters. A special meeting was called for the following evening, at which the W.A. White group discussed the overall situation. Possible avenues of procedure were considered. These meetings increased the level of interest and promoted the convergence of viewpoints. The final chapter of the Movement was soon to be written.

Additional Contacts. During these months, Drs. Laughlin, Masserman, Merin, and other colleagues did all they could on behalf of the Academy Movement and its concepts. In Chicago, on June 6, 1955, Dr. Masserman reported encouraging results by telephone to Dr. Merin.⁴⁸ Dr. Masserman indicated favorable responses to his recruitment efforts with people in San Francisco, Los Angeles, and Philadelphia.

Dr. Marmor⁴⁴ of Los Angeles reports his first contacts from New York in early

1955, at which time "I indicated my interest in participating."* Dr. Wolberg⁷⁴ wrote of several interested members in the Horney group, including Drs. Freeman and Bella S. VanBark+. Not only was sentiment crystallizing around the country, but additional leadership was enlisted. The Academy was gaining favor as a liberal new national scientific forum in psychoanalysis. Two important meetings took place in the fall of 1955 in New York. These helped set the stage for the final act in organizing the Academy—an event which took place in Chicago the following spring.

Intergroup Meetings in New York.

Differences Resolved. The first meeting was held at the offices of the W. A. White Institute, Croydon Hotel, West 86th Street, New York City, on October 7, 1955. The meeting brought together the leaders of the four established independent psychoanalytic groups in New York City. In addition to those from W.A. White, prominent psychoanalysts represented the NYMC, Columbia University, and the American Institute for Psychoanalysis. This was solid evidence of the implementation of the unification goal.

Among the active participants were Drs. Thompson, Crowley, and Rioch Bard of W.A. White; Kardiner of Columbia; and Silverberg and Bieber of NYMC. Many practical considerations involved in establishing the new national group were mutually and cooperatively explored. Final differences were largely resolved, and it was decided to proceed further. In pursuit of this undertaking, Dr. Rioch Bard was named to arrange a wider meeting.

With the collaboration of Drs. Spiegel, Tauber (a later trustee), and Thompson—all faculty members of the W.A. White Institute—a letter of invitation was drafted and mailed by Dr. Rioch Bard on October 28, 1955. This was sent "to people whom we thought would be interested" and who might "consider it most worthwhile to organize such a forum or academy."⁵¹ In line with earlier statements of policy, the letter stated, "The intent of this new academy is to fill an existing need...this academy in no

sense conflicts with other scientific affiliations...and your support...does not require nor suggest an abrogation of membership in any other organization."***

The 1953 policy change by W.A. White leaders, which would have strictly limited initial participation to APsaA members, had been rescinded (p.703). The once-formidable barriers to unification no longer stood in the way. The leaders could now

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* Dr. Marmor continued to participate. On January 15, 1966, he was elected founding fellow (seniority number 130) in the ACP and in the ACPsa (seniority number 37) April 27, 1971. In 1991, he received the presidential award of the Academy for "outstanding contributions to psychoanalysis."

** Most APsaA members who became affiliated with the Academy continued to maintain memberships in the older organization. Likewise, some W.A. White people retained longstanding memberships in the Washington Psychoanalytic Society.

proceed cooperatively and on equal footing. When the second meeting was convened, there was greater support and assured success.

Meeting Convened. Fifty-one prominent psychoanalysts representing all area groups, including a number from more distant centers,* attended this meeting held on December 3, 1955** in the auditorium of the NYMC, 106th Street off 5th Avenue, New York City. This time was chosen to coincide with the winter meetings of the APsaA, so that analysts from around the country could more readily attend.

Dr. Jewett welcomed those present. Dr. Rioch Bard was elected chairperson, and Dr. Spiegel was named secretary. Plans for the Academy were presented, stressing that its value would rest on its merits as a scientific organization.

Commitment to Proceed. Active participants also included Drs. Nathan W. Ackerman†, William G. Barrett of San Francisco (who soon became president of the APsaA,*** 1956), Bernard, Bieber, Eckardt,¹⁷ Levy, Crowley, Kardiner, Kelman, Lief, Marmor, Millet, Rado, Silverberg, Romm, Thompson, and Henry A. Davidson**** as parliamentarian.¹⁶ Discussion included important organizational and procedural matters. In line with the general consensus, an enabling resolution was offered by Dr. Silverberg. Passed with some modifications, this outlined the purposes of the proposed national psychoanalytic association and advocated its formation.

The passage of the Silverberg resolution was an important milestone. It served as a commitment to proceed and to forge the last link in the long chain of events that characterized the Academy Movement. The final organizational meeting was held the following April in Chicago. Prior to the final chapter, let us take a backward glance at how things progressed around the country.

Drs. Masserman, Laughlin, Merin, and Bieber

The Chicago Area. Work on behalf of the Academy continued to move ahead in other areas. In Chicago, Dr. Masserman was one of the first NCSPP members and was its area representative. He was influential for several years in promoting

* Dr. Laughlin did not receive a copy of the Rioch letter and was not present.

** According to Dr. Millet.^{49,52} Dr. Marmor⁴⁴ recalls it as the second.

*** Early in the course of this meeting, Dr. Barrett "introduced a resolution that the Academy should be open to psychotherapists who were dynamically oriented. This was an inimical move and one which had been designed to kill the essential psychoanalytic nature of the organization." Its passage would have vitiated the purposes and goals of the Academy Movement. When the prospect of these deleterious effects became apparent, the Barrett resolution was defeated by vote.^{41,49,51}

**** Dr. Davidson was also the parliamentarian for the APA. It was Dr. Spiegel's idea "to call in Davidson, as a paid consultant to facilitate this work and to have it done on a professional level."^{2,68}

the Academy Movement. Dr. Grinker,²³ a prominent Chicago analyst and sixth Academy president (1961-62), reported that most of his early information came from Dr. Masserman.* So did Dr. Garner,²¹ who was included in the NCSPP in fall 1952.

Dr. Masserman⁴⁶ reported to Dr. Laughlin the substance of several personal contacts on behalf of the Movement with Dr. Alexander, whom he had also confidentially evaluated personally. Dr. Alexander became the eighth president of the Academy and, unfortunately, died on March 8, 1964 while still in office. He was originally contacted about the Academy in fall 1952 by Dr. Laughlin,³ and again by Dr. Ham.²⁴

Dr. Masserman's contacts in the Chicago area were valuable. He recommended to the NCSPP in late 1952 nearly two dozen analysts in various centers around the country as being excellent, liberal people who should be considered as prospects.

Dr. Alexander was initially reserved and equivocal about the Academy concept. On November 6, 1952, however, he expressed "deep interest" in the Academy and exchanged letters with Dr. Laughlin, using NCSPP stationery. Dr. Masserman confirmed his interest at dinner in Chicago. Dr. Ham also talked and corresponded with him. One letter of Dr. Alexander, dated December 16, 1952, was forwarded for NCSPP files and is still extant. Dr. Ham reported the progress of his communications to NCSPP colleagues.

Dr. Masserman's contacts in the Chicago area** were valuable. He recommended to the NCSPP in late 1952 nearly two dozen analysts in various centers around the country as being excellent, liberal people who should be considered as prospects. Shortly after, he agreed to do "some of the recruiting." In this connection, he reported several successes, with interest elicited from Drs. H. Flanders Dunbar+ (who died on August 21, 1959), Nathaniel Apter, Louis Schwartz, and Harry August.

In December 1952, Dr. Masserman endorsed Dr. Thompson's⁶⁹ recommendations of Drs. Kardiner and Rado as "the logical people" and Dr. Binger, "a man of scientific integrity who would surely be an asset" from Columbia University. He also endorsed Dr. Millet,^{***} fourth presi-

* In summarizing Dr. Masserman's early role, he originally learned about the Academy Movement in a letter from Dr. Laughlin dated June 2, 1952. This accompanied a copy of the agenda and an invitation to attend the Washington Intergroup Conference scheduled for later that month. He did not plan to attend, although in his reply of June 13, 1952, he expressed interest. This was again indicated in a letter dated July 8, 1952.

In September 1952, he became an active supporter. After carefully reviewing the provisional constitution in some detail that month, he duly endorsed it by signature stating, "My overall endorsement is only partially indicated by my signature; as I wrote you, I am an enthusiastic supporter of the new organization of the Academy."^{1,46}

** In confirmation, Dr. Garner²¹ wrote, "I doubt if without his efforts Alexander, Grinker and Apter would have been among the Movement's supporters and I felt that the Chicago people in general had the experience of seeing Jules in the role of a founder."

*** Dr. Millet was born on July 8, 1888, in Broadway, England. Coming to the United States, he graduated from Harvard in 1914. His early postgraduate work included 1923-30 at Austin Riggs and 1931-35 at the New York Psychoanalytic Institute. He had a long and distinguished career as a teacher, researcher, and clinician. For many years, he was a leading analyst at the Psychoanalytic Clinic at Columbia and, after 1959, a professor of psychiatry and assistant dean at the New York School of Psychiatry. In 1962, he was named honorary consultant at the Columbia Psychoanalytic Clinic.

Dr. Millet enjoyed great respect as a scholar and author. He was a nationally recognized leader of the liberal and progressive elements in psychiatry and psychoanalysis for more than three decades.

dent of the Academy, 1959-60, and historian, 1956. He stressed Dr. Millet's potential value—an evaluation that confirmed earlier ones dating from July and October. Dr. Millet had first been cited in summer 1952 as "the best person" to contact the liberal Columbia leaders, including Dr. Levy.

Dr. Masserman did not hesitate to proffer advice and was always ready to "go along with the majority." Letters were shared with him, and he was kept in touch with developments. His contributions to the NCSPP and the Academy Movement were much appreciated. Others he suggested included Drs. John M. Dorsey, I. Arthur Mirsky, Fromm-Reichmann, Bernard C. Glueck Jr., Martin Grotjahn, and Maskin, all of whom (except Dr. Glueck who resigned in the mid sixties) were active in the Academy Movement.

Dr. Masserman subscribed to the original Academy concepts and principles supporting the Movement. He was active in the NCSPP and served on the editorial board of the *NCSPP Newsletter*. He devoted time and thought to prospective supporters and the Academy through its formative years. His continuing interest in the Academy and its history included going over the early drafts of this document. While working on his manuscript for *A Psychiatric Odyssey*⁴⁷ in June 1969, he requested "with your permission to incorporate as much of it as possible in the final version."⁴⁶

The Washington Area. In Washington, Dr. Laughlin continued encouraging sentiment for the Academy, maintaining communications, handling administrative chores, promoting concurrence of views, and seeking to calm the ripples of the ongoing internal crosscurrents. There were additional Washington-Baltimore area people with whom discussions are believed to have been held prior to 1955, including Drs. Jean G.N. Cushing* of Baltimore; John M. Fearing, Paul Chodoff, Robert G. Kvarnes, and probably Edward M. Ohaneson of Washington; Dexter M. Bullard, Sr.** of Rockville; and Edwin A. Weinstein, and Herman A. Meyersberg of Bethesda. Also deserving mention are Drs. Jarl E. Dyrud of Chicago and Bela R. Reiger of Garden City, who lived in the Washington area at the time. Robinson, a friend and confidant, continued his encouragement and advice.⁶⁵

There were continuing friendly contacts with Drs. Eckardt (who became a Bethesda resident and was the seventh Academy president), Zuger, Lussheimer, Van Bark, Martin, and Freeman—all of the AAP in New York. In addition to the unfortunate death of Dr. Horney, there were other regrettable losses. Before too long, Dr. Cruvant moved to St. Louis, where he died a few years later. Dr. Burtneck, a longstanding friend, staunch supporter, and early NCSPP associate, was forced to forego active participation soon after developing lymphoma in 1953; he died four years later.

The Movement continued to make gains, although it inevitably suffered losses.

* Dr. Cushing became founding fellow (seniority number 19) of the ACPsa on May 4, 1970, also serving as its second secretary general, with Dr. Laughlin as president, 1970-71.

** He became an early charter fellow of the ACP on January 30, 1965 (seniority number 54).

Fortunately, there were more than enough gains to counterbalance the losses. By the close of 1954, an initiator was no longer needed. The initiation phase had succeeded and the Academy Movement was well off the ground. Many people knew about its basic concepts; a fair number of psychoanalysts accepted them as worthwhile, valid, and obtainable; and a gratifying measure of progress had been achieved. Although a considerable base existed, there was merit in continuing to promote the Academy Movement—a course which Dr. Laughlin continued.

His personal endeavors, however, could proceed on a lower key since the NCSPP people and an increasing group of colleagues were becoming more dedicated. Further, the spread of interest and commitment took place in increasingly larger concentric circles and probably could not even have been halted. Finally, Dr. Laughlin judged it to be advantageous to the Movement to have more of the drive shared by others. Their motivation, commitment, and efforts would expand accordingly.

The contributions of the pioneers made the final implementation of the goals propitious. The professional soil grew more favorable for their optimal lodgement and growth.

The Movement continued to make gains and inevitably suffered losses. Fortunately, there were more than enough gains to counterbalance the losses.

New York and the Society for Medical Psychoanalysis. Close communication continued to be maintained with Dr. Merin. For several years, he represented the Movement with his colleagues in the New York SMP, a major independent group. At a meeting in mid-1955, his interest was confirmed as it had been through repeated contacts. He also developed and maintained constructive relationships with other leaders.

A more recent, meaningful relationship was established with Dr. Wolberg. Dr. Wolberg, who served as an Academy trustee,¹⁴ was in a strategic position being a member of both the Silverberg (SMP) and the W. A. White groups. He and Dr. Masserman were provided by Dr. Merin in May 1955 with another copy of the provisional constitution.⁴⁸ Dr. Merin was always ready to help. His frequent letters were encouraging over the years, often praising Dr. Laughlin's endeavors and accomplishments.

Dr. Bieber, who became an Academy trustee, (1961-64) and sixteenth president (1971-72), like Drs. Merin and Fisher, was prominent in the SMP. Aloof for a time, he kept his "finger on the pulse" of the Movement from September 1952, and his personal interest had been indicated long since. In November 1952, he assured Dr. Laughlin that despite his reserved position, "needless to say I am eager that the present effort be the successful one and I'll do all I can to make it so."⁸

In 1954, Dr. Bieber visited New Orleans to discuss the formation of the Academy with Drs. Heath, Monroe, and Lief.⁴¹ As noted earlier, he played an active role in the 1955 meetings. Dr. Mumford,⁵⁵ the second editor of the newsletter, recalls that two conferences were held in Dr. Bieber's apartment.

Drs. Martin, Lussheimer, Ham, Heath, Monroe, and Lief

A Staunch Friend. In New York, the high level of interest of the AAP leaders

Table

Leaders in the Academy Movement

The following is an alphabetical list of analysts who were prominent in the Academy Movement and in the early leadership of the American Academy of Psychoanalysis.

Nathan W. Ackerman *~ d.	Paul Lussheimer @
Franz Alexander *~ d. 3/8/64	Judd Marmor *~
Kenneth E. Appel *~ d.	Alexander R. Martin *~ d.
Frances S. Arkin*~ d.	Meyer H. Maskin *
Janet Mac K. Rioch Bard *~	Jules H. Masserman *~@
Irving Bieber *~ d. 8/91	Milton Mazer *
Carl A.L. Binger	Joseph H. Merin ~@d.
Daniel Blain d.	Jean Baker Miller ~
Albert Bryt*	John A.P. Millet *~ d.2/1/76
Dexter M. Bullard ~ d.	Russell R. Monroe *@
Lester L. Burnick @ d.12/17/57	Robert S. Mumford
Morton B. Cantor~	Sandor Rado *~ d.
Paul Chodoff ~	Alfred H. Rifkin ~ d.
Ralph M. Crowley *~ d.	Robert L. Robinson **d.
Bernard A. Cruvant @ d.5/7/65	May E. Romm *~ d.
Jean G.N. Cushing d.	Leon Salzman *~
Howard Davidman ~	Leon J. Saul ~@d.
Henry A. Davidson **	John I. Schimel d.
John M. Dorsey d.	William V. Silverberg *~ d.10/10/67
H. Flanders Dunbar d.8/21/59	Herbert Spiegel *~
Edna G. Dyar * d.1967	Edward S. Tauber *~ d.
Marianne H. Eckardt *~	Clara M. Thompson *d.12/20/58
Saul H. Fisher @	Bella S. Van Bark *
Nathan Freeman *~	Edith H. Weigert *d.
Frieda Fromm-Reichmann *~ d.4/28/57	Wanda Willig @
Harry H. Garner @	Earl G. Wittenberg *~
Sidney S. Goldensohn ~ d.	Eric D. Wittkower ~ d.
Roy R. Grinker, Sr. *~	Lewis R. Wolberg *~ d.
George C. Ham @ d.9/26/77	Miltiades L. Zaphiropoulos *
Robert G. Heath *~	Bernard Zuger @
Mary White Hinkley *	
Karen Horney d.12/4/53	*Charter Fellow
Abram Kardiner * d.	~Officer or Trustee
Harold Kelman *~ d.	d. Deceased
Elizabeth Kilpatrick *~	@ NCSPP member
Henry P. Laughlin @	**Non-analyst
Nolan D.C. Lewis d.12/18/79	
Harold I. Lief *~	

(Thanks to Dr. Marvin G. Drellich, the current (1992-1993) Academy president and very early academy fellow, for his helpful provision of updates on the necrology on June 9 and 16, 1992.)

had not abated. Dr. Martin continued to be a staunch friend and advocate. He loyally supported the endeavors and the NCSPP as the active arm of the Academy Movement and helped enlist the support of a number of important people.

In recalling his reactions, Dr. Martin wrote⁴⁵ to describe how he found himself "keenly interested in bringing about some degree of healthful relationship between the different dissident groups, that from my viewpoint had so much in common." Dr. Martin, who later served as an Academy trustee (1958-61), continued his interest in the Academy, providing assistance through his encouragement and reviews.

Association for the Advancement of Psychoanalysis Support. Dr. Lussheimer enthusiastically mobilized AAP support, especially during 1952-53.

Support and affiliation of AAP members were recommended, marking a historic and momentous action by the officers of a psychoanalytic association.

Dr. Lussheimer never failed to convey warm and friendly feelings with sincerity, kindness, a scholarly attitude, and abiding faith in the Academy Movement. Some of this dated from before his first meeting with Dr. Laughlin in 1953 and is attested to by the copies of a dozen pieces of correspondence which are extant.^{1,42,56} In November 1952, he wrote, "I feel that the organization you are planning will be of the greatest importance for all doctors in psychoanalysis. I personally am very much in favor of your endeavors for the Academy and shall be glad to cooperate with you to the best of my abilities."

A member of the NCSPP from November 16, 1952, Dr. Lussheimer, AAP president, was a leading supporter during his term. He discussed its aims and purposes with its executive council in December 1952. They presented the NCSPP promotion of the Academy at the next regular meeting of the AAP in January 1953. Dr. Laughlin's conception of the Academy, the Movement, and the NCSPP were discussed and viewed quite favorably by the association. Support and affiliation of AAP members were recommended, marking a historic and momentous action by the officers of a psychoanalytic association.

Dr. Lussheimer assured Dr. Laughlin of his conviction "that the majority of our members will support your work." Dated December 5, 1952, a letter of tribute and condolence was addressed to the AAP on behalf of the NCSPP, following Dr. Horney's death. Copies were sent to Dr. Lussheimer, as well as to Drs. Willig, Martin, Eckardt, and Zuger. In response, Dr. Lussheimer confirmed the NCSPP's conviction that "Horney's death* deprived your Committee of one of its sincerest supporters."⁴²

Dr. Lussheimer became an even stronger advocate following a conference with Dr. Laughlin in January 1953 at Dr. Lussheimer's West End Avenue apartment in New York. Dr. Lussheimer provided sound advice and offered to review the current draft of the constitution.** His stance in regard to the Academy was never in doubt.

* Dr. Horney died on December 4, 1952. The NCSPP letter was read to the AAP membership at their monthly meeting in January 1953⁷³ by Dr. Willig, AAP secretary.

** Dr. Lussheimer took a copy of the Academy constitution along with him for study during his vacation the week of December 18, 1952.

This was illustrated in a 1954 letter: "You know how enthused I am about your plan for the Academy, which is so very excellent, and my interest is just as much alive in your planned organization as it was on the first day I heard about it...I wish and hope that the coming year will mean greater progress towards its realization."

The commitment of the AAP leaders was solid from the beginning. Dr. Lussheimer derived gratification from the advancement of the Academy Movement and his own participation in it. In another letter to Dr. Laughlin he recalled "great pleasure in the work we did together."⁴² Similar support came from Drs. Martin, Merin, Saul, Millet, Grinker, Zuger, Ham, Bullard, Robinson,⁶⁵ Mumford,* Eckardt, Fisher, and others. This support provided a continuing stimulus in compiling these historical notes.**

From Chapel Hill and New Orleans. Support for the Academy Movement remained secure in other quarters. From Chapel Hill, Dr. Ham continued his interest in the Academy, assuring his NCSPP associates that "you still enjoy my interest and support."²⁴

In regard to the attitudes of the leaders of the Tulane University group in New Orleans, Dr. Monroe⁵³ indicated to Dr. Laughlin the "enthusiastic support" of himself and Dr. Heath. Dr. Heath²⁶ wrote separately, promising to "boost the organization in every way possible." He served as a trustee, 1956-58.

Dr. Lief, in New Orleans, was the third Tulane leader who was prominent as an Academy supporter. He made a trip to Mexico in the summer of 1955 to visit Dr. Bieber who was vacationing there, "to discuss various aspects of the development of the Academy."⁴¹ Dr. Lief has been prominent in Academy affairs for many years, becoming a charter fellow along with his two Tulane colleagues. In 1967-68, Dr. Lief served as its twelfth president.

Dr. Lief continued his friendship and organizational participation with Dr. Laughlin. He became a founding fellow (seniority number 34) in the ACP on May 30, 1965 and also a charter fellow of the ACPsa (seniority number 86) on January 15, 1973. The American Society of Physician Analysts elected him an honorary member.

William A. White Policy Reversal

Common Cause Evolved. In 1954, the leaders of the APsaA inadvertently provided another major boost to the Academy Movement. This assisted in bringing to fruition one of the Academy Movement's earliest objectives—bringing closer

* Dr. Mumford of New York City and Old Greenwich has long been a friend and collaborator of Dr. Laughlin. He was a founding fellow (seniority number 9) of the ACPsa, August 21, 1969 and, after years of service as secretary-general, was elected president. On March 28, 1967, he was elected to fellowship in the ACP.

** For example, Dr. Millet's kind "conclusion that your work [on this manuscript] has made a significant contribution to the truthful recording of events in our field, and that my admiration for your industry and imaginative planning cannot be overstated."⁴⁹ He continued his participation in Dr. Laughlin's organizational endeavors, becoming a founding fellow of the ACPsa on April 27, 1971 (seniority number 35) and in the ACP on January 20, 1972. He continued these affiliations until his death on February 1, 1976.

the various independent psychoanalytic groups and their members. The APsaA hierarchy made a serious and threatening move against its members who were also affiliated with the two independent institutes headed by Drs. Silverberg and Thompson.

This unquestionably provided those under attack with increased motivation to develop a common cause, almost forcing them into defensive cooperation. The beneficial effects for the Academy Movement of this hostile move by the senior organization should have been foreseen by members who were its opponents.

The attitudes and policies of some toward the burgeoning Academy Movement, especially the W.A. White Institute leadership, were at various times warmer or colder. Their policies were inextricably tied to the ebb and flow of their continuing struggles with the APsaA.

The most climactic and crucial event in furthering the Academy Movement in 1954 was the APsaA's threat to expel members who taught in psychoanalytic institutes not accredited by the older group.

The most climactic and crucial event in furthering the Academy Movement in 1954 was the APsaA's threat to expel members who taught in psychoanalytic institutes not accredited by the older group. This hostile move was specifically directed against the W.A. White and New York Medical Institutes' senior faculty members. The intent was to hamper them professionally or affect their dissolution, but the effort backfired.

An Irreparable Breach. The threatened action comprised the crowning blow in destroying what had been excellent and constructive relationships, alienating these able analysts. Possibilities for future rapprochement seemed hopeless for both sides. Drs. Thompson and Silverberg—accomplished and widely respected pioneers in American psychoanalysis—were driven further away. Their increasing commitment to the Academy Movement as the best alternative for their future in national organizational affiliation was practically ensured.

Dr. Silverberg and the nine senior W.A. White faculty members who were also affiliated with the APsaA defended themselves and their professional positions, securing legal help to counter the threat. Abe Fortas, with the prestigious Washington law firm of Arnold, Fortas and Porter,* intervened. This was under a restraint of trade action against an alleged violation of the anti-monopoly laws. The hazard was successfully averted. However, the damage was done. The resulting increase in bitterness on both sides led to the breach becoming irreparable.

Restrictive Stand Relaxed. These were stormy years, and many complex factors contributed to the problems that were present. Nonetheless, 1950-56 was

* Fortas was a potential member of the United States Supreme Court.

Drs. Silverberg and Thompson were personally disappointed that Dr. Hadley, director, and other colleagues in the Washington-Baltimore Institute failed to support them adequately in their struggles with the parent organization. This was particularly true in view of the leading roles of the two in the founding and subsequent contributions to the development of the society and institute.

Dr. Thompson, a founding member at the early age of 36, had been elected the first president of the Washington-Baltimore Society on May 27, 1932. Dr. Silverberg was elected its first secretary-treasurer also in 1932, when he was only 32.

an essential period in the Academy's gestation. The W.A. White leaders came to use the name "Academy" for the proposed organization.

Dr. Mumford⁵⁵ reports, "The existence of the Academy Movement was most useful for us at the White Institute." This was true even during 1953-54 when the W.A. White leadership was more aloof. However, they relaxed their reserved stand, again subscribing to the more liberal Academy viewpoint.

This was a commendable remodification of their course and was very constructive.* Dr. Thompson recognized this many months before. She commented that their interim policy "would have left out many of the people who are already interested in your plan for the Academy."⁶⁹ It was an essential hurdle to overcome, and accomplishing this cleared the way to proceed.

Effective Leadership. The W.A. White leaders could now provide much of the final impetus and leadership for the Academy Movement. They proceeded to do so effectively.

The wisdom of following along with the original plans more closely has been borne out by the fine caliber of scientific contributions and leadership provided the Academy by excellent people from the originally contemplated groups. Otherwise, their affiliation, worthwhile contributions, and loyal support might have been deferred, if not lost altogether. Substantial progress has been possible because of these distinguished members, who comprise a valued segment of the organization.

* By 1955, prior membership in the APsA was no longer considered a requirement by the W.A. White's senior people for inclusion in the Academy's membership. In regard to this, Dr. Rioch Bard,⁶⁴ who became the Academy's first president (1956-57), stated that "this latter point I thoroughly agreed with, since it would have been contrary to the purposes of the Academy to have the charter members restricted to the American Psychoanalytic Association membership."

The Final Chapter

Chicago, 1956. The concluding event in implementing the organizational goals of the Academy Movement took place on Sunday, April 29, 1956, in the Burgundy Room of the Morrison Hotel in Chicago. About 34 nationally prominent psychoanalysts who subscribed to the Academy concept attended. They included persons from the original groups and all sections of the country, and represented many others who were not present but had a stake in the Movement.* On this occasion, these people duly completed the last chapter in the official establishment of the American Academy of Psychoanalysis, bringing to fruition the Academy conception that had been so carefully evolved earlier (1947-52) and painstakingly nurtured (1952-55).

The members were appointed and charged with proposing a slate for election of the first permanent officers of the organization.

The meeting was opened shortly after 3:00 p.m. by Dr. Rioch Bard. She was elected chairperson for this occasion, and later the first president of the Academy. Dr. Spiegel was named secretary, and Dr. Davidson served as parliamentarian.¹⁶ The enabling resolution of Dr. Silverberg was carried over from the December meeting in New York and was re-adopted. Authorization was given the chairperson to appoint a nominating committee. The members were appointed and charged with proposing a slate for election of the first permanent officers of the organization.

A Considerable Achievement. This final meeting was marked by its friendly, cooperative, and constructive tone. Those present or absent were in substantial agreement, the major differences of opinion having been resolved. The professional atmosphere was excellent.

This reflected the constructive results of careful preparations, the mobilization of favorable sentiment, thoughtful discussions by many fine people, and careful and deliberate pace of movement. It also represented a considerable achievement and afforded a nontangible but significant reward for everyone who had participated in the Academy Movement.

In light of the long-term antecedent endeavors, which were at times arduous, the events of this particular day were almost anticlimactic. The constitution offered by Dr. Spiegel's committee (and Dr. Masserman and Dr. Davidson) was presented, and with a few changes and policy items added, the constitution was completed and adopted. Provisions were included for the category of scientific associates, and qualifications for fellowship were confirmed as earlier outlined.

All Groups Included. The nominating committee was carefully selected to include a representative from all but one of the original groups. The inclusion of these members long had been advocated and staunchly planned for. The nominating committee was comprised of Dr. Crowley (W.A. White) as chairperson, and Drs. Kardiner (Columbia), Kilpatrick (AAP), Dr. Romm (Independent), and

* Again not including Dr. Laughlin.

Dr. Silverberg (NYMC) as members. A slate of candidates was presented, and the meeting adjourned at 5:00 p.m.

Those elected to office were excellent people. Included were leaders from each group and area as outlined earlier. Most had also enjoyed a role in the Academy Movement. Holding the honor of first officers in the Academy were:

President—Dr. Janet MacK. Rioch Bard

President-elect—Dr. Jules H. Masserman

Secretary—Dr. Francis S. Arkin

Treasurer—Dr. Leon Salzman

Trustees—Drs. John A. P. Millet and William V. Silverberg (three years), Robert G. Heath and Frieda Fromm-Reichmann (two years), and Elizabeth Kilpatrick, Herbert Spiegel, and Clara M. Thompson (one year).

...they all shared in the great enthusiasm that made the Academy Movement a success.

Many Contribute. Others in addition to those named above participated in the proceedings or had prominent roles in the years to follow. These included such stalwarts as Drs. Rado, Grinker, Martin, Weigert, Lief, Saul, Marmor, Kelman, Nathan W. Ackerman, Kenneth E. Appel, Maskin, Salzman, John L. Schimel, Earl G. Witenberg, Freeman, Natalie Shainess, Eric D. Wittkower, Chodoff, Don Jackson, and Donald Bloch.

The names and contributions of the leaders, together with those of Drs. Alfred K. Rifkin, Howard Davidman, Sidney S. Goldensohn, Morton B. Cantor, Iago Galdston, Jean Miller, and a dozen more, have been significant. Some were committed to the Academy Movement since its inception or shortly after, as were many of the earlier officers and trustees. While the interest of others was more recent, they all shared in the great enthusiasm that made the Academy Movement a success. They made professional, scientific, and organizational contributions that have ensured subsequent progress.

Success and Vindication. The early principal officers are listed chronologically on the following page. Note that the Academy frequently called upon the early people for leadership and how well the various groups were represented. The enviable position of the American Academy of Psychoanalysis today reflects the early officers' levels of enthusiasm, excellence, and achievements and it clearly vindicates the ideas, confidence, and endeavors of the Movement's founder, his friends, colleagues, and associates, who joined in fraternal fashion during 1951-56 to become the Movement's founding fathers, and later the majority who became the Academy's charter fellows. Finally, the success of the Academy reflects the loyalty and dedication of many able and talented fellows.

Table
Early Principal Officers of the American Academy of Psychoanalysis
A Chronological Roster

Year	President	Secretary	Treasurer
1956-1957	Dr. Janet MacK Rioch Bard	Dr. Frances S. Arkin	Dr. Leon Salzman
1957-1958	Dr. Jules H. Masserman	Dr. Frances S. Arkin	Dr. Leon Salzman
1958-1959	Dr. William V. Silverberg	Dr. Frances S. Arkin	Dr. Leon Salzman
1959-1960	Dr. John A.P. Millet	Dr. Joseph H. Merin	Dr. Leon Salzman
1960-1961	Dr. Frances S. Arkin	Dr. Joseph H. Merin	Dr. John L. Schimel
1961-1962	Dr. Roy S. Grinker, Sr.	Dr. Joseph H. Merin	Dr. John L. Schimel
1962-1963	Dr. Sandor Rado	Dr. Alfred H. Rifkin	Dr. John L. Schimel
1963-1964	Dr. Franz Alexander	Dr. Alfred H. Rifkin	Dr. Earl G. Witenberg
1964-1965	Dr. Leon Salzman	Dr. Alfred H. Rifkin	Dr. Earl G. Witenberg
1965-1966	Dr. Judd Marmor	Dr. Howard Davidman	Dr. Earl G. Witenberg
1966-1967	Dr. Ralph M. Crowley	Dr. Howard Davidman	Dr. Earl G. Witenberg
1967-1968	Dr. Harold I. Lief	Dr. Sidney S. Goldensohn	Dr. Morton B. Cantor
1968-1969	Dr. Harold Kelman	Dr. Sidney S. Goldensohn	Dr. Morton B. Cantor
1969-1970	Dr. Alfred H. Rifkin	Dr. Sidney S. Goldensohn	Dr. Morton B. Cantor
1970-1971	Dr. Eric D. Wittkower	Dr. Jean Baker Miller	Dr. Morton B. Cantor
1971-1972	Dr. Irving Bieber	Dr. Jean Baker Miller	Dr. Morton B. Cantor
1972-1973	Dr. Marianne H. Eckardt		Dr. Ralph Slater

Once seemingly long, the gestation period of the Academy proved to be a considerable advantage to the Movement, and the length of this period has likewise been vindicated. It contributed substantially to its delivery being more propitious. The progress in status of the Academy over the years has been especially gratifying to pioneers committed to the Academy Movement. Their convictions have been confirmed, and their dedication proven most worthwhile. They have had the satisfaction of their expectations being fulfilled.

The Academy Movement succeeded. The Academy is a significant national organization and has well fulfilled the aims, goals, and expectations of the early pioneers.

Henry P. Laughlin, M.D., Sc.D., Sc.S.D.

Frederick, Maryland, 1958

(edited & revised 1969, 1970, 1971, and 1991-92)

Table
Charter Fellows of the Academy of Psychoanalysis*

Nathan Ward Ackerman, M.D.	Alexander Reid Martin, M.D.
Franz Alexander, M.D.	Meyer Maskin, M.D.
Kenneth E. Appel, M.D.	Jules H. Masserman, M.D.
Frances S. Arkin, M.D.	Milton Mazer, M.D.
Irving Bieber, M.D.	John A.P. Millet, M.D.
Walter Bonime, M.D.	James Clark Moloney, M.D.
Hilde Bruch, M.D.	Russell Ronald Monroe, M.D.
Albert Bryt, M.D.	Ruth Moulton, M.D.
Stella Chess, M.D.	Lilly Ottenheimer, M.D.
Gerard Chrzanowski, M.D.	Sandor Rado, M.D.
Ralph M. Crowley, M.D.	Arnaldo Rascovsky, M.D.
Charles Clay Dahlberg, M.D.	Janet MacKenzie Rioch, M.D.
Louis De Rosis, M.D.	Bernard S. Robbins, M.D.
Edna G. Dyar, M.D.	May Ethel Romm, M.D.
Marianne H. Eckardt, M.D.	Leopold Rosanes, M.D.
Eugene A. Eisner, M.D.	Nathan Roth, M.D.
Louis C. English, M.D.	Leon Salzman, M.D.
Harmon S. Ephron, M.D.	John L. Schimel, M.D.
Ramon Fernandez-Marina, M.D.	William V. Silverberg, M.D.
Saul H. Fisher, M.D.	Raymond Sobel, M.D.
Nathan Freeman, M.D.	Herbert Spiegel, M.D.
Frieda Fromm-Reichmann, M.D.	Rose Spiegel, M.D.
Joseph J. Geller, M.D.	Edward S. Tauber, M.D.
Louis Jay Gilbert, M.D.	Clara Thompson, M.D.
Leon N. Goldensohn, M.D.	Montague Ullman, M.D.
Geneva Goodrich, M.D.	Bella S. Van Bark, M.D.
Alexander Gralnick, M.D.	Edith Weigert, M.D.
Roy R. Grinker, M.D.	Edwin A. Weinstein, M.D.
Robert Galbraith Heath, M.D.	Frederick A. Weiss, M.D.
Mary White Hinkley, M.D.	Antonia Wenkart, M.D.
Ada Hirsh, M.D.	Mabel Wilkin, M.D.
Stephen P. Jewett, M.D.	Earl G. Witenberg, M.D.
Lillian Kaplan, M.D.	Lewis R. Wolberg, M.D.
Abram Kardiner, M.D.	Alexander Wolf, M.D.
Aaron Karush, M.D.	Miltiades Zapiropoulos, M.D.
Edwin Kasin, M.D.	
Harold Kelman, M.D.	
Sarah Kelman, M.D.	
Elizabeth Kilpatrick, M.D.	
Harold Isaiah Lief, M.D.	
Judd Marmor, M.D.	

*From the first list published by the Academy of Psychoanalysis in 1957–1958, with Dr. Fromm-Reichmann's name added—she having predeceased this publication. Copy kindly provided by Dr. Marvin G. Drellich. (6/16/92)

Postscript

Personal Effects

Feelings Re-created. Reading this account of the Academy Movement today—years after it was originally written (1958) and more than 40 years since originating the basic concepts (1947-51)—is interesting and stimulating. It was written with help from various fellow pioneers and colleagues in an attempt to preserve some of the atmosphere and professional events of the times. Rereading the manuscript re-creates them vividly.

In retrospect, 1940-60 were rather troubled and stormy years in psychoanalysis. A backward glance from the added perspective of still another twenty or thirty years, however, may view this era simply as another ripple in the progression of any adolescent science or art struggling toward maturity.*

Having been thoroughly caught up in it personally and buffeted about a bit, its recall tends to create anew some of the emotional feelings and reactions of the times, albeit mellowed by the intervening years. Their recrudescence in this fashion encouraged the indulgence of adding this more personal postscript to the history. Writing it was also fostered by certain comments made by Drs. Grinker, Crowley, and others.**

From 1947 to 1951, I came to recognize the potential value of combining forces of several established and successful analytic groups with a fair number of progressive analysts around the country. The result of such an achievement would be a more liberal new national association of psychoanalysts.

As described in the preceding pages, conditions in psychoanalysis contributed toward making this a propitious endeavor. My research for a suitable name in 1951 resulted in my selecting, adopting, and introducing the name "Academy"—its first such professional use in the United States.

Following the friendly and encouraging Atlantic City meeting in Dr. Horney's suite in the Chalfonte Plaza Hotel in May of the following year, I founded the Academy Movement. I also established the NCSPP to serve as its basic support group and as the predecessor for the nascent American Academy of Psychoanalysis.

Over the years, as detailed in this history, I pursued with diligence the professional acceptance of the Academy concept. I secured acceptance and support in varying degrees from analytic friends and from a geographically representative circle of liberal professionals in the field.

Efforts to contribute to the campaign led to my writing a number of drafts and circulating among supporters the advance version of an Academy constitution. Similarly, I drafted and circulated copies of the *NCSPP Newsletter*, in addition to

* Viewing these from the vantage point of another three decades (1992) further confirms this. Fortunately, psychoanalytic organizations are even more liberal today.

** Dr. Grinker²³ wrote to say "The history of the Academy is only valuable if the truth be said...." Dr. Crowley¹⁴ also commented, "I think you should tell it like it was." Several other friends have so urged, noting that the inclusion of more personal material makes this historical account more interesting and more likely to live on.

attending conferences, traveling, writing letters, and making phone calls (for which I absorbed the costs) to promote the planned Academy.

Age. Being a younger, if not the youngest, participant in the Academy Movement was at times a disadvantage. This was very evident in some aspects and more subtle in others. I was 31 to 35 years old while originating the Academy concept. My position in psychoanalysis was quite junior. I began my analytic training upon completion of military service in the U.S. Navy Medical Corps, after the close of WWII.

When I broached the subject of the Academy to Drs. Thompson, Horney, and others at the Chalfonte Plaza suite in May 1952, I was not yet 36. Senior analysts might have considered my enthusiastically pursued activities as brash or questioned such temerity. It would not be too surprising.

It might be noted that Dr. Thompson had been the same age when she was a founder, leader, and first president of the Washington Psychoanalytic Society eighteen years earlier.

In any event, the endeavor was not rendered easier by my junior status. This may have contributed to my being omitted at its culmination. All this applied more strongly to my role as leader in spearheading the Academy Movement. Early on, this had been essential. Someone had to initiate. Someone had to assume leadership. There was no other choice. I sought to share or turn over this position to others on a number of occasions. For various reasons they declined, even though my role may have evoked resentment in some quarters. Prior to the fruition of our cause becoming more imminent, this position may have seemed to carry too many risks.

Tempered Satisfaction. I experienced satisfaction following each step of progress. Pleasure was derived each time new support and backing was secured from some friend or colleague around the country. I also experienced personal gratification and feelings of vindication with the formal establishment of the Academy. These feelings continue as it serves its intended functions.

Relationships were at times impaired as a consequence of spearheading the Movement, when for some people it was a highly controversial undertaking. This was at times painful. However, as noted earlier, certain misgivings and opposition were expected (p.717).

In each organizational endeavor, there have been detractors on personal and organizational fronts. Some have had inimical effects, hurting on both fronts. Despite this, each new group has served satisfyingly significant functions, proving valuable and flourishing since.*

* Only one no longer exists in its own right. In 1955, the Washington branch of the APA was merged with the Washington Psychiatric Society. The combined organization has continued to progress and currently numbers over 1,200 members.^{7,39}

My feelings about my W.A. White confreres assuming the final initiative was favorable. There was a great deal of pleasure and satisfaction over the resulting progress. On the other hand, I was very disappointed about being excluded at the finale. I also regret the failure of several close cohorts to speak out more clearly about my early endeavors.

Acknowledgment Minimal. I did not personally know the first Academy president. She largely headed the two final organizational meetings. Unfortunately, my name was not included in Dr. Rioch Bard's addressees for invitations, and I did not receive a notice of the December 3, 1955, New York City meeting nor the final Chicago meeting of April 29, 1956. Accordingly, I was unable to be present, let alone participate—either of which I would have dearly loved. Dr. Rioch Bard was uninformed until later about my extensive spadework in preceding years.*

Dr. Masserman was one of the earliest supporters of the Academy Movement. In 1956, he became the first president-elect, succeeding Dr. Rioch Bard the following year to become the Academy's second president, 1957-58. His role and contributions to the Movement, especially through the very early days, have been carefully documented.

During Dr. Masserman's presidency,⁴⁶ he wrote a letter assuring his old compatriot of "my conviction that you should be among us with full credit for your early contributions."** He promised he would do everything he could to bring this about, but nothing came of this.

For his excellent biographical book, *A Psychiatric Odyssey*, published in 1971,⁴⁷ Dr. Masserman ultimately decided not to include any of the material from this history, permission for which he had earlier requested. Instead, he authored his own history of the Academy. He wrote in 1969, however, to assure me that "I have listed you prominently among the pioneers in my book. Again, on February 27, 1970, he reported, "My new book is in press, and contains an account of the Academy with due credit to yourself."***

Dr. Merin later served simultaneously as the Academy's secretary and chairperson of the membership committee during 1958-62. Not elected president, however, his position in the Academy's hierarchy and politics was a bit junior, which would

* Dr. Rioch Bard kindly volunteered in 1971 that "had I been clear about your earlier activities, when I was chairman and then first president, I would certainly have given you appropriate credit, and I regret not to have done so."⁶⁴ I had been led to assume that more of my colleagues in the W.A. White group were aware of my antecedent prominent position in the Academy Movement over some years.

** Dr. Mumford has reported similar sentiments to me.⁵⁵

*** Dr. Masserman's choice to begin his own history of the Academy was simply to start with the final organizational meeting in Chicago in May 1956. As noted earlier, this event was almost anticlimactic. In a terse footnote he acknowledged merely that "invaluable preliminary work had also been contributed by Dr. Henry Laughlin of Washington, DC." Quoted in its entirety, this mention is a bit less than might have been anticipated.

It hardly reflects the extent of the author's endeavors and struggles on behalf of the Academy over the prior years. There is also no inclusion of the valued contributions of a score or more of the pioneers to the NCSPP, the Movement, and the Academy. The significant respective roles of the various groups and their leaders as detailed in the preceding pages were not mentioned.

not enhance his ability to initiate efforts to secure some kind of recognition for his Academy Movement compatriot or others. Many other pioneer colleagues have also been prominent in the affairs of the Academy since 1955-56.

A number of people in the Academy Movement have enjoyed positions of prominence and were well aware in some measure of my role and its extent. This, however, often accomplished little in informing those who were not. As an example, a leading officer* on one occasion asserted that I "had nothing to with the founding of the Academy." Although I knew how incorrect this was, as one who had figuratively bled on behalf of the Academy for years, it was painful.

Official acknowledgment of my role in the Academy Movement has been minimal. It has been limited to references by Dr. Millet in his accounts as Academy historian,^{50,51} plus those by Dr. Masserman.^{46,47} This had been less true on a more personal level, as attested by file letters from various colleagues over the years. One beneficial result of the lack of recognition has contributed to the energy required to compile this history of the Academy Movement.

As the original manuscript was being edited in the fall of 1971, Dr. Millet kindly advised me of his plan to recommend me for honorary membership,** "the least that the Academy could do in recognizing all the years of footwork that you put into the preparatory planning." This was not achieved. Much later, Dr. Millet's proposal was seconded quite spontaneously by nationally prominent analyst Dr. Sidney Berman of Washington (a trusted friend and confidant since the 1940s***) on June 1, 1991.

Professional Effects

Spreading Circles. The provisional constitution (p. 707), had some continuing beneficial effects of a broader nature on those who read, studied, and reviewed it. More significant have been the constitution's direct and indirect effects upon other organizations.

On a number of occasions, this antecedent constitution has served as an excellent model when drafting constitutions of several other leading professional bodies. Like the spreading concentric circles when a stone is dropped into a pond, there were also meaningful effects on the psychiatric field when their constitutions in turn influenced additional groups.****

* Dr. Salzman in 1959.

** Proposed formally by Dr. Millet to Dr. Bieber, president, on September 18, 1971, "as the one who first conceived the idea and name for the American Academy of Psychoanalysis," stating his belief "that many others of our founding members would support his nomination for this honorable recognition of all the work that he did in years gone by."²

*** Dr. Berman was earlier elected an honorary member of the American Society of Physician Analysts. A professional compatriot, Dr. Berman, along with me, became a founding fellow of the ACP (seniority number 45) June 8, 1963 and of the ACPsa (seniority number 36) April 2, 1971.

**** Dr. George E. Gardner, a long-esteemed friend and colleague in professional matters, so reported, having used the second generation constitution of the Eastern Psychoanalytic Association, while serving as AACP by-laws chairperson, as a model for the American Academy of Child Psychiatry in 1968-70. Note also another professional adoption of the name "Academy" (pp.679 and 692).

An Inadvertent Contribution. Most of my Academy friends and colleagues indicate their conviction that the Academy Movement has been successful, that the original spirit has continued,* and that its major objectives have been achieved.** These accomplishments are evidenced through the successful establishment of the American Academy of Psychoanalysis and its commendable progress.

It is possible to assess additional professional effects and benefits of the Academy Movement and the resulting organization now that several decades have passed. Although strictly personal, these observations should be more detached by now. This has to do with certain indirect and presumed influences on the older APsaA and the field of psychoanalysis. Having blundered into an organizational morass and seemingly becoming professionally sclerotic in the early years, the failure of the APsaA to adequately meet the needs of a significant group of both senior and junior liberal analysts inevitably made a substantial contribution to the birth of the Academy Movement.

Leavening Influence. That the Academy should have a leavening influence on the earlier sacrosanct and rigidly orthodox policies of the APsaA is a bit ironic. It is difficult to say how many people from the older organization would acknowledge this. Nonetheless, APsaA attitudes and policies during the past three decades (1960–1992) have not reflected the same degree of dogmatism or authoritarianism as earlier described. These attitudes were sometimes manifested quite intolerantly and in virulent form.

In addition, I think there has been some withering away of the earlier intolerances that were often expressed toward those who held more liberal viewpoints. These latter viewpoints had been thoroughly eschewed by the old guard, and their proponents were at times subjected to powerful condemnation.*** Orthodoxy,

* In confirmation, Dr. Eckardt,¹⁷ seventeenth Academy president (1972-73), wrote, "The organization has maintained its original spirit. This I believe is due to the careful preparation that went into the constitution, and this of course resulted from the many discussions and meetings that you initiated."

** Most, but not all. One distinguished past president wrote, "I had envisaged the Academy as a psychoanalytic GAP stirring up American psychoanalysis toward openness, flexibility and change. Perhaps nobody could accomplish this, but the Academy in its own role failed...In sum, I am glad we tried with the Academy....but I am disappointed at our failure and am sorry to have to write this."² Others, of course, feel oppositely and believe that at least in some measure these goals have been achieved.

***"Fortunately, organizations can grow up and mature too!" commented Dr. Bernard Bandler recently during a discussion with me concerning the more liberal attitudes in the APsaA during the past decade or so. ⁴ President of the senior association in 1959, during the stormy controversy over possible collaboration with the American Board of Psychiatry and Neurology, Dr. Bandler today vividly recounts how he was accused of being "Hitler" by some of his ex-European colleagues, such as Dr. Kurt Eissler, who were prominent in the APsaA hierarchy at that time. For additional data about this earlier controversy (in regard to which Dr. David A. Boyd wrote,⁹ not entirely seriously, that Dr. Bandler "was lucky to escape with his life."). See Masserman JH. *A Psychiatric Odyssey*. New York: Science House. 1971.

Dr. Bandler has long been an excellent friend and collaborator. Elected a fellow (seniority number 309) January 1, 197, of the ACP, he was also a charter fellow (seniority number 66) April 25, 1972 of the ACPsa. He was elected the tenth president of the latter prestigious organization May 7, 1978 and, later, served commendably as the editor of the ACPsa newsletter for years.

with exceptions, has been less vigorously pursued. The old zeal and fervor seem less religious in tenor.

The dogmatism of organized psychoanalysis in the forties and early fifties contributed to some of the anti-analytic bias of certain psychiatrist colleagues and professionals in allied fields. Despite widespread adoption and usage of many dynamic concepts in their daily work, a great deal of antagonism was generated and some became quite hostile to psychoanalysis. As the field and its organizational hierarchy became more liberal and flexible, the roles of these particular unfortunate contributions lessened substantially.

In observing the professional scene from a more detached viewpoint, there would seem to be more restraint today. Professional policies and organizational actions seem less intemperate and arbitrary. Since before 1960, the presence of artificially imposed limitations on professional development and discouraging attitudes toward the elaboration of psychoanalytic theory are less evident.

To the extent these impressions are correct,* the overall effects of the Academy Movement on psychoanalysis in the United States have been beneficial, constructive, and scientifically salubrious. From the broadest viewpoint, this might be its greatest accomplishment. As noted, it is ironic that this constructive and leavening influence should finally result in part from external developments, after widespread internal concerns and sincere endeavors from within the APsaA could not free it from the old-line influences and make it more flexible, liberal, and democratic. These restrictions were far more characteristic of the 1940s and 1950s, threatening to seriously cramp the development of psychoanalysis in America.

Results Constructive. In any event, and whether or not the Academy Movement is ever so recognized or credited with fostering such long-ranging liberalizing influences on psychoanalysis,** they should be welcomed by all in the field. We trust their effects are long lived.

Henry P. Laughlin, M.D., Sc.D., Sc.S.D.

Washington, DC, October 20, 1971 and Frederick, Maryland, July 14, 1992

* Checking my impressions with several colleagues indicates a measure of confirmation. As one example, Dr. Barton,⁶ a respected and objective observer, stated his belief that this assessment had some validity. As "a very important outcome of this influence," Dr. Millet⁴⁹ too cites, "the first formally acknowledged collaboration of the American Psychoanalytic Association with the Academy on a public platform...hopefully sparking a new spirit of ecumenism among psychoanalytic societies at the national level." He represented the Academy and Dr. Viola Bernard (who "is to be congratulated on her courage and liberality" for securing "the approval of the executive council to lend her name and connection to the program" as APsaA chairperson of the Committee on Community Psychiatry) the senior Association in "the role of co-chairmen of a successful symposium on Community Psychiatry for the World Mental Health Assembly, Washington, November 1969."

** Certainly true for many of the Academy's detractors, and likely even true for some Academy members. Liberalization in the field represented a most major goal among the aims that we as idealists sought from the beginning, and for which we thoroughly and steadfastly supported and promoted the Academy Movement despite any professional risks and hazards. The overall constructive results can well be hailed by all in the field of psychoanalysis. We can look forward to a brighter future, one which is less hampered by fixed attitudes and inflexibility.

Table
Forty Pioneers in the Academy Movement

Name	Date of First Contact	Source	Locale
1. Franz Alexander	Oct. 29, 1952	Laughlin/Ham	Chicago
2. Albert Bryt	May 9, 1952	Laughlin/Ham	Atlantic City
3. Ralph M. Crowley	May-Dec. 1952	Thompson/Laughlin	New York City
4. Irving Bieber	June-Nov. 1952	Merin/Laughlin	New York City
5. Lester L. Burtnick	Sept. 1951-May 1952	Laughlin	Washington
6. Bernard A. Cruvant	Jan.-May, 1952	Laughlin	Washington
7. H. Flanders Dunbar	Oct. 1952	Masserman	New York City
8. Saul H. Fisher	June-July 1952	Merin	New York City
9. Marianne H. Eckardt	Sept.-Oct. 1952	Laughlin/Horney	Wash. & NYC.
10. Nathan Freeman	Oct. 1952, May 1955	Horney/Wolberg	New York City
11. Freida Fromm-Reichmann	Oct. 1952	Thompson/Masserman	Rockville
12. Harry H. Garner	Oct. 1952	Masserman	Chicago
13. Roy R. Grinker, Sr.	Nov.-Dec. 1952	Masserman	Chicago
14. George C. Ham	May 22, 1952	Laughlin	Chapel Hill, later White Sulphur Springs
15. Robert G. Heath	June 12, 1952	Laughlin	New Orleans
16. Mary J. W. Hinkley	Mar.-June 1952	Laughlin	Washington
17. Karen Horney	May 10, 1952	Laughlin	Atlantic City
18. Elizabeth Kilpatrick	Oct. 1952	Horney	New York City
19. George Kriegman	June 3, 1952	Laughlin	Richmond
20. Henry P. Laughlin	1948-1952	Self	Washington
21. Harold I. Lief	1952-1953	Heath/Monroe	New Orleans
22. Paul Lussheimer	Nov. 18, 1952	Horney/Laughlin	New York City
23. Judd Marmor	1954	Laughlin	Los Angeles
24. Alexander R. Martin	May 9, 1952	Laughlin	Atlantic City
25. Meyer H. Maskin	Oct. 1952	Thompson	New York City
26. Jules H. Masserman	June 2, 1952	Laughlin	Chicago
27. Joseph H. Merin	May 9-10, 1952	Laughlin	Atlantic City
28. John A. P. Millet	Oct. 1955	Rioch et al	New York City
29. Russell R. Monroe	June 1952	Heath	New Orleans
30. Robert S. Mumford	May 1955	Wolberg/Spiegel/ Bieber	New York City
31. Janet Mc K. Rioch	June 1952	Thompson	New York City
32. May E. Romm	May 14, 1952	Thompson	Atlantic City & NY
33. Leon J. Saul	Oct. 12, 1952	Laughlin	Philadelphia
34. William V. Silverberg	Oct.-Nov. 1952	Bieber	New York City
35. Herbert Spiegel	May-Oct. 1952	Thompson	New York City
36. Clara Thompson	May 9, 1952	Laughlin	Atlantic City
37. Bella S. Van Bark	May 1955	Wolberg	New York City
38. Wanda Willig	Oct. 1952	Horney/Lussheimer/ Laughlin	New York City
39. Lewis R. Wolberg	May 1954	Masserman/Merin	Atlantic City & NY
40. Bernard Zuger	May 11, 1952	Laughlin	Atlantic City

Table
Colleagues Reviewing Manuscript Drafts

Date	
1958	<p>"Historical Notes on the Background and Origins of the Academy of Psychoanalysis" (Original Draft)</p> <p>Joseph H. Merin, July</p> <p>Jules H. Masserman, July</p> <p>John A. P. Millet, August</p> <p>Roy R. Grinker, Sr., September</p> <p>Leon J. Saul, October</p> <p>Alexander R. Martin, October</p>
1967	<p>Edited Manuscript</p> <p>John A. P. Millet, August</p> <p>Joseph H. Merin, August</p>
1969	<p>"The Academy Movement" (Second Draft)</p> <p>Jules H. Masserman, June</p> <p>Joseph H. Merin, July</p> <p>Paul Lussheimer, August</p> <p>Roy R. Grinker, Sr., September</p> <p>Judd Marmor, September</p> <p>Robert L. Robinson, September</p> <p>Cornelia Wilbur, October</p> <p>George C. Ham, October</p> <p>Alexander R. Martin, December</p>
1970	<p>Bernard Zuger, January</p> <p>Leon J. Saul, February</p> <p>Russell R. Monroe, March</p> <p>Harry H. Garner, April</p> <p>Saul H. Fisher, June</p> <p>John A.P. Millet, July</p>
1970	<p>"The Academy Movement" (Third Draft)</p> <p>Douglas Noble, August</p> <p>Ralph M. Crowley, August,</p> <p>Alexander Reid Martin, September</p> <p>Dexter M. Bullard, Sr., October</p> <p>Anne W. Bullard, October</p> <p>Cornelia B. Wilbur, October</p> <p>Robert L. Robinson, October</p> <p>Leon J. Saul, October</p> <p>Paul Lussheimer, October</p> <p>Joseph H. Merin, October</p> <p>Bernard Zuger, October</p>

- 1970
Continued
- Russell R. Monroe, November
Harry H. Garner, November
George C. Ham, November
Robert G. Heath, November
Helen A. De Rosis, November
John A. P. Millet, November
Bella S. Van Bark, November
Lewis R. Wolberg, December
Robert S. Mumford, December
Marianne Horney Eckardt, December
Harold I. Lief, December
Saul H. Fisher, December
- 1971 Edited Manuscript (further incorporating comments and data from reviewers)
- George B. Delaplaine, Jr., January
Robert S. Mumford, January
Harold I. Lief, January
Dexter M. Bullard, Sr., January
Anne W. Bullard, January
Ralph H. Meng, February
Alice Heyl Kiessling, February
Margaret Rioch Bard, March
Sandor Rado, March
Herman A. Meyersburg, March
Helen A. De Rosis, April
John A. P. Millet, April
Herbert Spiegel, July
Kenneth E. Appel, October
Eric D. Wittkower, October
George B. Delaplaine, Jr., October
Ralph M. Crowley, December
- 1991-92 Final Manuscript
- Sidney Berman
E. James Brady
Marvin G. Drellich
John R. Laughlin
M. Page Durkee Laughlin
Robert S. Mumford
Grant Angus Salisbury

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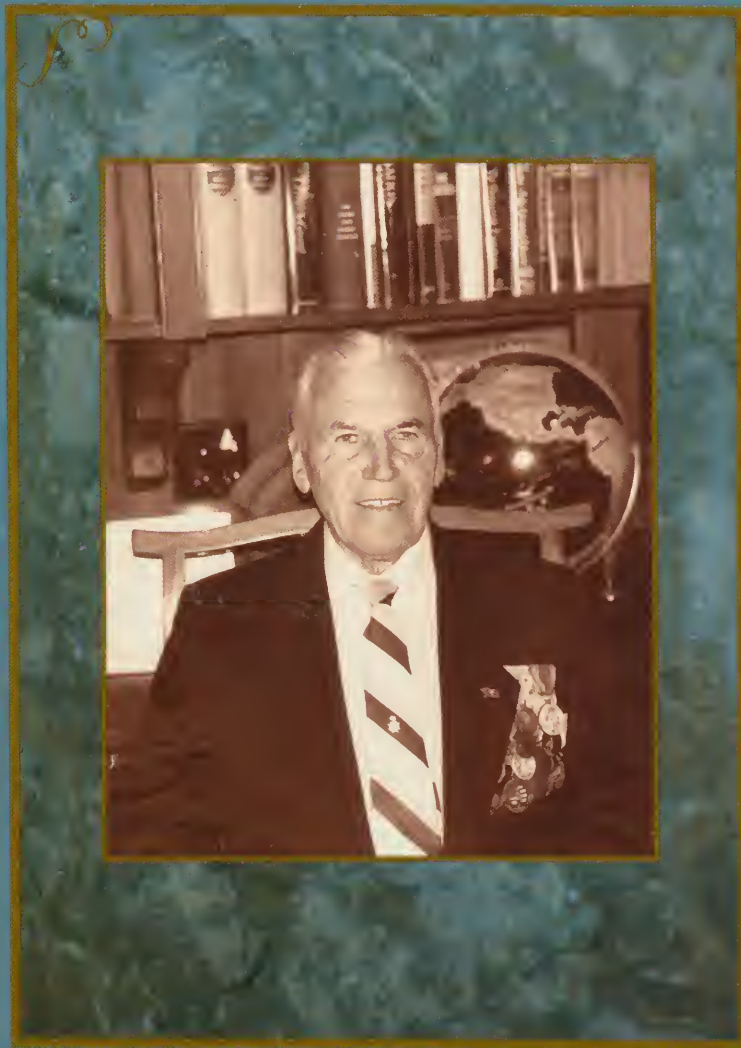
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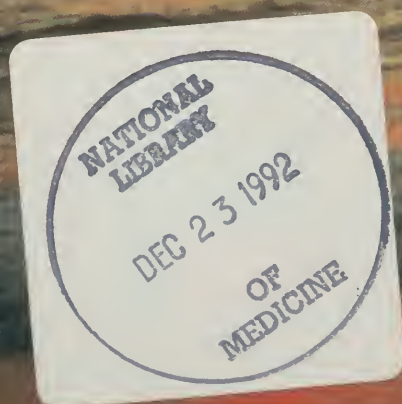
Henry P. Laughlin, M.D., Sc.D., Sc.S.D.

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‡Verapamil should be administered cautiously to patients with impaired renal function.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents.

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Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomasia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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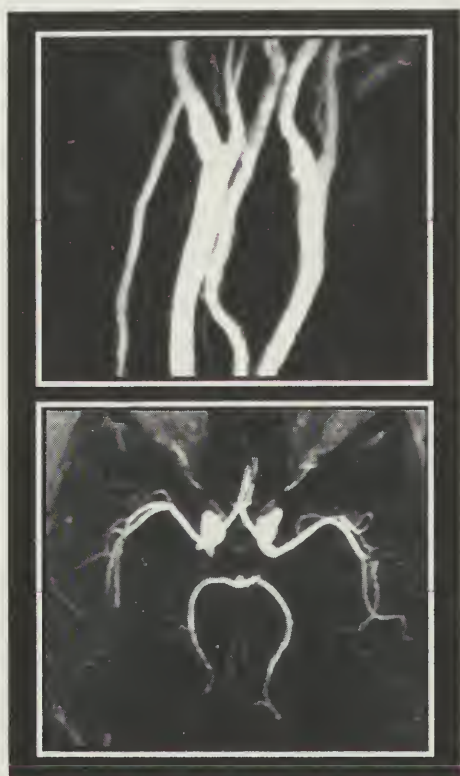
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Maryland Medical Journal

SEPTEMBER 1992

VOLUME 41 NO 9

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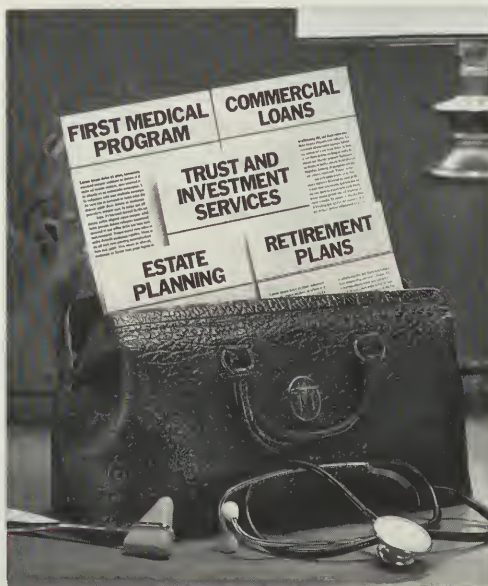
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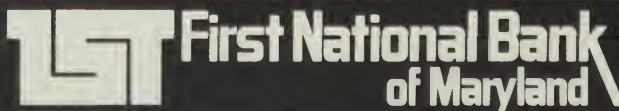


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#Case 22

A 17 year old male twisted his ankle playing basketball 3 weeks ago and still experiences pain and swelling.

DIAGNOSIS: Anterior talofibular ligament tear accompanied by a transchondral injury to the talus.

Most acute ankle sprains occur with inversion stress resulting in injury to the anterior talofibular or other lateral ligament. Symptoms usually resolve in 2-3 weeks. However, in some cases, the distal tibia exerts excessive impaction or shearing forces upon the talus causing a transchondral osseous injury. Although these lesions are occult on conventional radiographs, they are often responsible for prolonged pain and disability.

MRI is extremely sensitive to both osseous and soft tissue injury. Figure 1 demonstrates a normal anterior talofibular ligament (arrow) on an axial MR image and Figure 2 depicts the anterior talofibular ligament tear (small arrows) seen in this patient with an ankle sprain. Talus (T), Fibula (F). Figure 3 (sagittal image) illustrates abnormal subchondral marrow signal (arrowhead) representing a transchondral injury involving the talus. Recognition of this pathology is important, not only as an explanation for delayed resolution of symptoms, but also because these injuries may progress to actual osteochondral fragmentation and loose body formation. In addition to detecting radiographically occult osseous injury, MRI also proves valuable in assessing tendon integrity and in differentiating causes of foot and ankle pain.



FIGURE 1



FIGURE 2



FIGURE 3

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TOUGH, SMART AND YOURS

medical
economics
A May 1988

Successfully defending a brain-damaged baby case is the courtroom equivalent of pitching a no-hitter. Because the "sympathy factor" can add millions to a jury's award, many insurance carriers would rather settle than fight.

Not so the P-I-E Mutual Insurance Co. of Cleveland, Ohio, and the 1-year-old law firm—Jacobson, Maynard, Tuschman & Kalur—that does all its defense work. In 21 brain-damaged baby cases it has defended for the doctor-owned company, its record is a remarkable 19-1: the last a hung jury. In 1988, its over all record read 13 wins, 3 losses—all malpractice cases.

There's more to those numbers than luck. "It's even legal skill," adds JMT&K founding partner Aaron Jacobson, who was one of Ohio's leading plaintiffs' lawyers before he, Larry E. Rogers, Herbert S. Bell, M.D., and 70 other Cleveland doctors formed P-I-E in 1975.

"It's the concept behind the firm that makes it work. Physicians specially handle review every lawsuit to decide whether the defendant deviated significantly from the standard of care. If he did, we pay. If he didn't, we defend. Makes no difference whether it's a \$5,000 or a \$5 million case. We label it 'No pay.' That policy has resulted in a lot of cases being dropped. Perhaps more important, it's

DON'T YOU WISH THESE DEFENSE LAWYERS WERE YOURS?

This big, multistate firm rarely loses a case. But it's more than luck, or even legal skill, that's behind its enviable record.

By Howard Eisenberg

discouraged the filing of many other cases. Plaintiffs' attorneys have learned that we're fair negotiators when our doctor's in the wrong, but won't back down when he's right."

That approach pays off. "According to the most recent report I've seen from the General Accounting Office," says Larry Rogers, P-I-E president and CEO, "in 1984, about 57 percent of medical-malpractice claims were closed without payment. Through 1988, we've closed an average of 78 percent of our cases without a dime changing hands. And it's my understanding that, without including defense costs, St. Paul Fire and Marine Insurance Co.'s 1988 average gross payout for cases closed in Ohio with payment was \$52,500. Our comparable figure was about \$10,000 below

theirs. That's partly why we can sell an OBG specialist in Ohio—an industrial state that ranks among the most litigious—\$1.2 million in coverage for just \$20,000."

The unique marriage of P-I-E and JMT&K has been so successful that the carrier has expanded into five other states: Indiana, Kentucky, Maryland, Missouri, and West Virginia. Where P-I-E goes, there goes JMT&K, with nine branch offices to date. The firm has 63 trial attorneys, and may well be the nation's largest devoted well-versed exclusively to medical-malpractice defense. Could the insurer-defender symbiosis, if duplicated by other doctor companies, make a significant contribution to reducing malpractice litigation nationwide? An up-close look at

how JMT&K operates may help to answer that question.

Every lawyer develops a medical specialty

"Our firm's lawyers read more medical books than law books," says P-I-E Vice President Gerald C. Ogenorth, himself a veteran defense attorney. Robert Maynard explains, "New cases are discussed at our weekly staff meeting, so that every lawyer is familiar with every case. But we assign cases to our attorneys according to medical specialty. They're well-versed in their fields, so they don't have to reinvent the wheel with each case."

Last year, the firm's OBG specialist, attorney Jerome S. Kalur, who had won 16 consecutive brain-damaged baby cases, faced one of his toughest challenges when he defended a GP

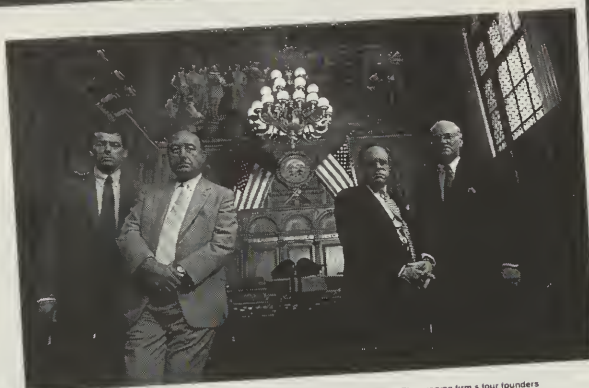
which attempted a midforceps delivery that ended in a Caesarean section and a severely brain-injured baby. Recalls Kalur, "I didn't think the doctor had caused the damage, but our position was weakened by the fact that he didn't have midforceps privileges. Based on that departure from the standard of care, our doctor panel voted to settle, and, since the hospital was also involved, a combined sum of \$1.5 million was offered. Plaintiffs turned us down flat."

"I wanted to depose the doctors who'd been involved in the mother's care during her hospitalization, but the attorney for the plaintiff baby insisted it would violate the mother's physician-patient confidentiality. That privilege would terminate automatically when her medical

The winning firm's four founders at Cleveland's 8th District Court of Appeals (from left): Jerome S. Kalur, Aaron Jacobson, James M. Tuschman, and Robert Maynard.

records were introduced at the tail end of the plaintiff's case. Meanwhile, I was in the position of having to tell the jury, 'It couldn't have been the midforceps,' without offering them another reasonable brain damage theory."

Fortunately, the plaintiffs rested their case on a Friday afternoon, giving JMT&K time for a weekend rally. "Twenty minutes later," says Kalur, "I was in the hospital pathologist's office with an order permitting me to view the mother's placental slides." Meconium staining had been charted, and Kalur had a hunch that fetal distress had begun long before the for-



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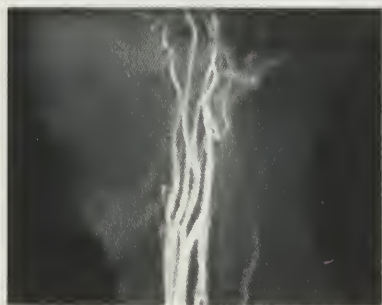
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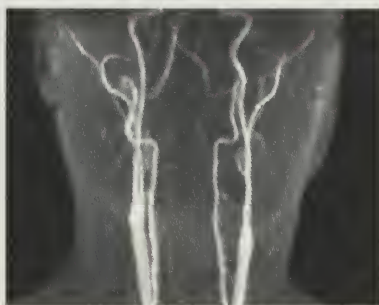
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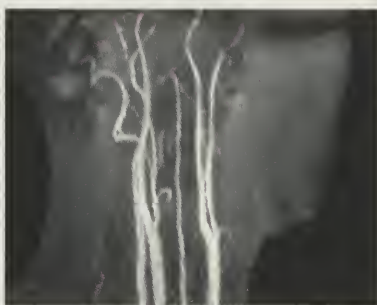
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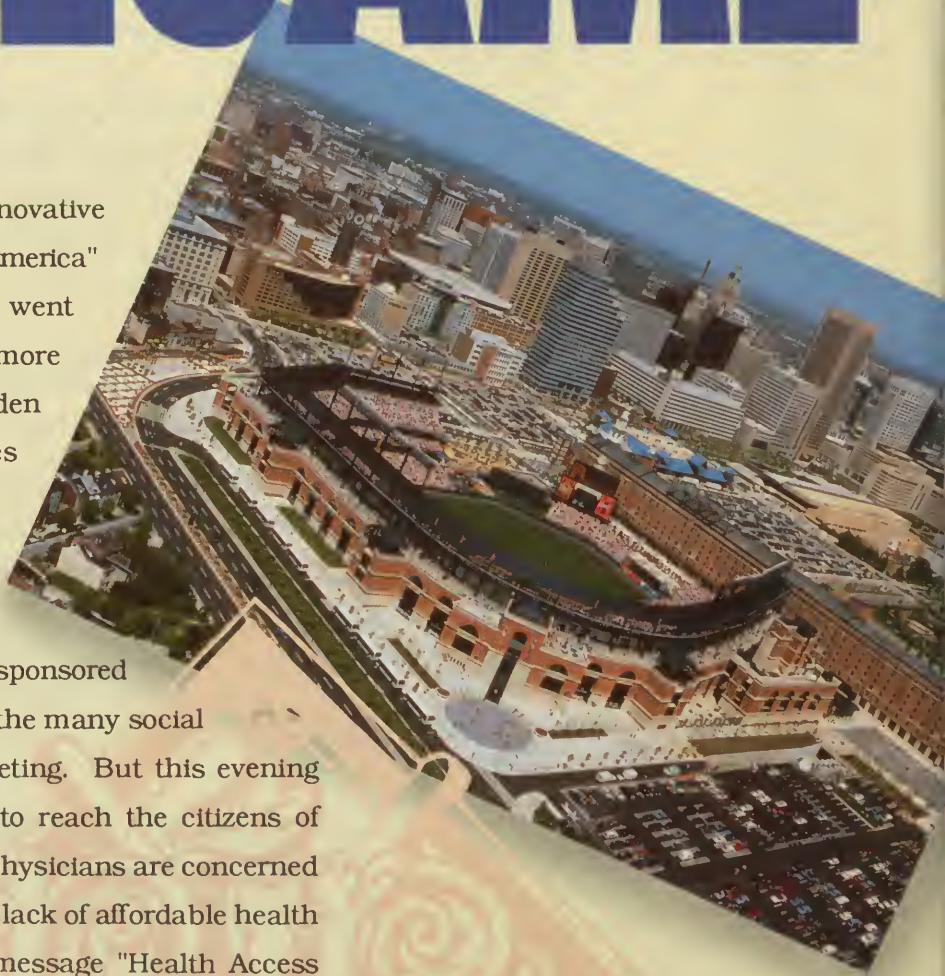
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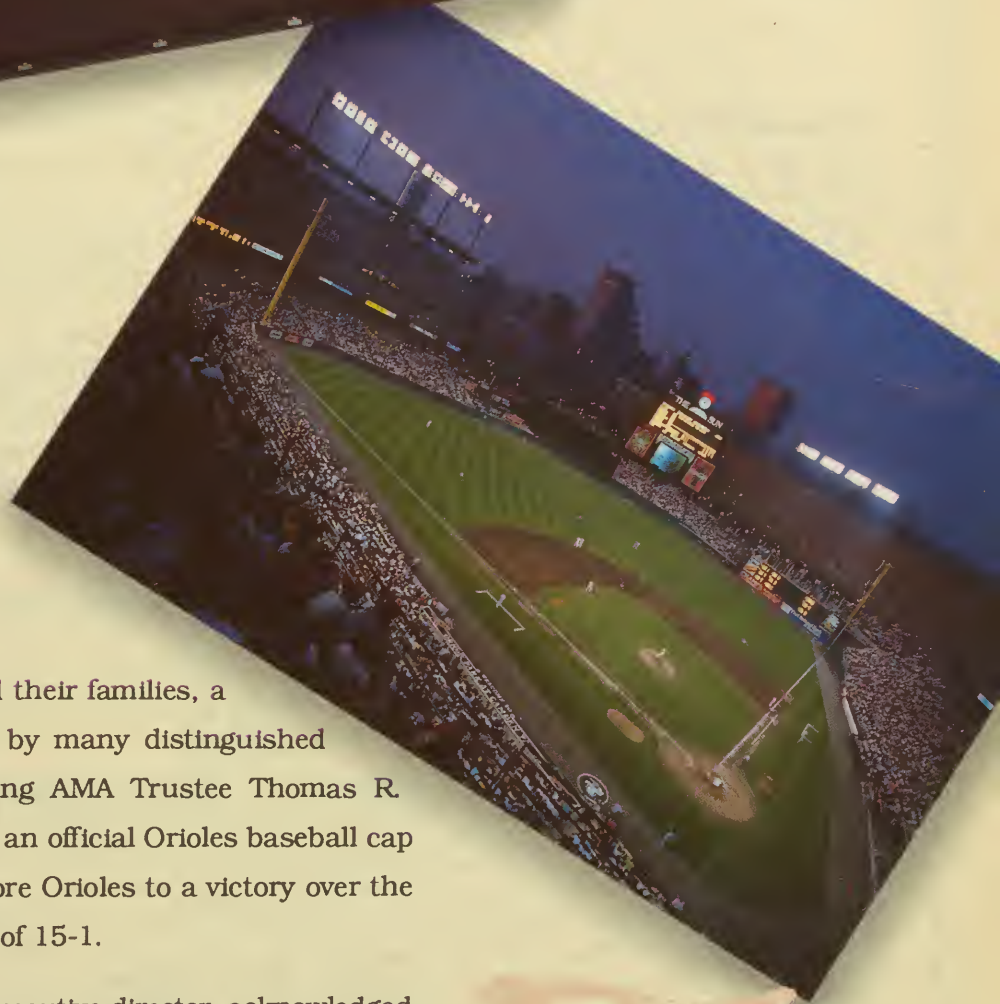
Maryland physicians take
message of "Health Access America"

OUT TO THE BALLGAME

In search of an exciting and innovative way to bring the "Health Access America" message to the public, Med Chi went straight to the hottest spot in Baltimore this season—Oriole Park at Camden Yards, where tickets sometimes command prices four times their value and are sold out six weeks prior to game dates.

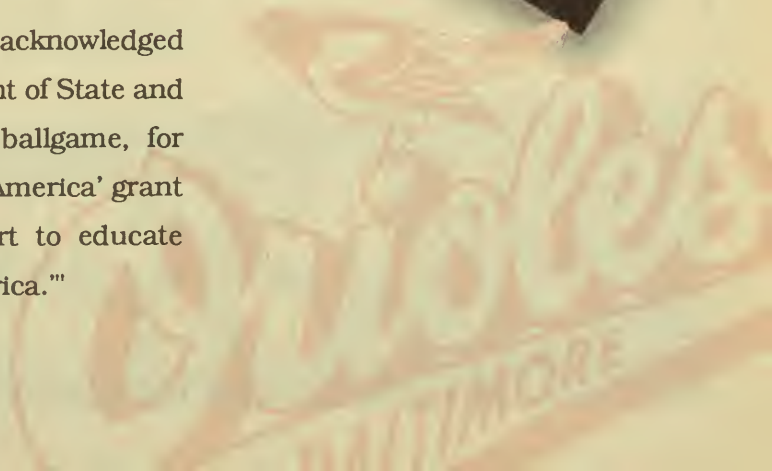
On Friday, May, 1 1992, Med Chi sponsored a night at the ballpark, just one of the many social events held during the annual meeting. But this evening was special, for the purpose was to reach the citizens of Maryland and let them know their physicians are concerned about escalating health costs and a lack of affordable health care. Med Chi arranged for the message "Health Access America—MDs Care" to be displayed on the Orioles' new JumboVision scoreboard.





Maryland physicians and their families, a group of 250, were joined by many distinguished out-of-state guests including AMA Trustee Thomas R. Reardon, M.D, who sported an official Orioles baseball cap and helped root the Baltimore Orioles to a victory over the Seattle Mariners by a score of 15-1.

Angelo Troisi, Med Chi's executive director, acknowledged the efforts of Mike Murray, AMA vice-president of State and County Relations, who also attended the ballgame, for "helping Med Chi obtain the 'Health Access America' grant and for making possible this creative effort to educate Maryland citizens about 'Health Access America.'"



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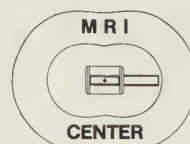
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Executive Director's Newsletter

September 1992

OSHA Regulations on Bloodborne Pathogens

In August, Med Chi sponsored five training sessions designed to help physicians and their office staff comply with the federal regulations on occupational exposure to bloodborne pathogens. The programs were presented by Robert J. Ancona, M.D., chairperson of the Immunizations and Infectious Diseases Subcommittee; Roseanne M. Matricciani, R.N., J.D, assistant executive director for healthcare policy; and Diane Dwyer, M.D., chief, Center for Clinical Epidemiology, Department of Health and Mental Hygiene.

More than 500 physicians and their office staff attended these sessions at which physicians and their office staff were told how they could comply with these regulations. The training session included

- the AMA's videotape, "For Your Protection: The OSHA Regulations on Bloodborne Pathogens,"
- a review of transmission modes for bloodborne pathogens,
- a review of ways to prevent exposure to potentially infectious materials,
- procedures to follow if an accident occurs involving potentially hazardous materials,
- a review of the OSHA regulations, and
- a question and answer period addressing specific practice problems and situations.

According to the regulations, physicians are responsible for assuring that all employees with an occupational exposure have been fully trained and that this training information is documented. Each medical site was to develop an exposure plan by July 31, 1992, and each site was to have completed employee training by August 31, 1992.

To assist physicians in meeting this new obligation, Med Chi is sponsoring two additional sessions for physicians in southern and eastern Maryland.

Eastern Maryland
September 4, 1992
Memorial Hospital
Easton, Maryland

Southern Maryland
September 22, 1992
Physicians Memorial Hospital
La Plata, Maryland

For more information about these sessions, contact Joan Mannion at 410-539-0872 or 1-800-492-1056.

RBRVS Update

The American Medical Association's (AMA's) Specialty Society Relative Value Scale Update Committee (RUC) will provide recommendations to the Health Care Financing Administration (HCFA) for updating Medicare's resource-based relative value scale physician payment schedule. The committee is composed of physician representatives from the AMA, 22 medical specialties, the American Osteopathic Association, and the CPT Editorial Panel.

Donald T. Lewers, M.D., past-president of Med Chi and vice-chairperson of Med Chi's AMA Delegation, is an AMA representative to RUC and vice-chairperson of RUC.

CLIA

Administrator William Toby of the Health Care Financing Administration (HCFA) has agreed to a ninety-day extension on claims submission requirements for the implementation of CLIA. Under terms of the extension, HCFA will not deny a Medicare claim for laboratory services submitted prior to December 1 for lack of a CLIA registration form or CLIA number. Also, HCFA has authorized the Maryland Medical Assistance Program to continue payments, on and after September 1, 1992, to providers who have not supplied their CLIA

certification. These payments are subject to subsequent review and recovery should the provider not later submit the required documentation. To obtain information on how to participate in the CLIA program, please call the CLIA Hot Line at 410-966-6802 or call 410-290-5850 or write to

HCFA CLIA Program
P.O. Box 26689
Baltimore, MD 21207-0489

Questions concerning Maryland State Laboratory exceptions or permits should be directed to the Certification Division of the Laboratories Administration at 410-225-6080.

CLIA Inspections

The AMA has advised Health and Human Services Secretary Louis W. Sullivan, M.D. that CLIA inspectors should announce their visits prior to inspecting physician offices. While unannounced visits are appropriate when inspectors suspect a problem or when they are responding to a complaint, routine inspections should be announced so that patient care will not be disrupted.

Biomedical Research

Both the House and Senate passed the Animal Enterprise Protection Act of 1992, which provides criminal penalties for acts of violence against research efforts. The bill broadly defines enterprise to include facilities that use animals for food or filler production, agriculture, research or testing, and lawful competitive animal events.

Needy patients—Drug Directory

A directory is now available to physicians seeking information about free medications for needy patients. To obtain a copy of the directory write to: 1992 Directory of Prescription Drug Indigent Programs, Pharmaceutical Manufacturers Association, 1100 15th Street, N.W., Washington, DC 20005 or call 1-800-PMA-INFO or 1-202-393-5200 for physicians living in the DC area.

Electronic Claims

The Workgroup for Electronic Data Interchange (WEDI) presented recommendations for a standardized electronic billing system to the Department of Health and Human Services. The AMA was a member of the workgroup and chaired the advisory group on confidentiality. A copy of the workgroup's report can be obtained by writing to WEDI, P.O. Box 527, Glenview, Illinois 60025.

The workgroup's goals are to

1. develop common data policies, format, and standards;
2. demonstrate the cost-effectiveness of data interchange; and
3. produce a five-year extension plan.

Respiratory Care Practitioners Must Be Certified

In August 1992, the Maryland Board of Physician Quality Assurance (BPQA) announced that the practice of respiratory care in Maryland is now a certified health care occupation. Since the new regulations were passed on November 11, 1991, the BPQA has certified 1,263 respiratory care practitioners. The certification program went into effect May 11, 1992.

Only certified respiratory care practitioners are permitted to practice respiratory care independently in the state of Maryland. Practicing respiratory care without certification may result in referral to the local state's attorney for prosecution.

For more information about the program, call 410-764-4777.

Hospital Library Broadcast

The University of Maryland will play a two-part satellite broadcast, "Information STAT: Rx for Hospital Quality," on October 22 and November 5, 1992. The program, which will assess the critical role information services can play in improving hospital quality and cost-effectiveness, is sponsored in part by the Na-

tional Library of Medicine and the Medical Library Association. Members of the Maryland Association of Health Science Libraries, their administrators, supervisors, and library committee chairpersons, as well as university personnel, are invited to the viewing. For more information about the broadcast, contact Susan Bailey at 1-800-338-7657.

Upcoming Med Chi Events

Physicians should mark their calendars for upcoming Med Chi meetings:

1. President's Regional Conference—Western Maryland

Thursday, October 22, 1992 at 4:30 p.m.

at the Sheraton in Hagerstown, MD

This conference is for members in Garrett, Allegany, Washington, Frederick, and Carroll counties and is intended to address the concerns of physicians in western Maryland. A one-hour continuing medical education presentation will be made during this meeting addressing "Medical Management in Home Care." For more information about this conference, contact Joan Mannion at 410-539-0872 or 1-800-492-1056.

2. President's Regional Conference—Eastern Shore

Thursday, November 5, 1992

at the Cambridge Yacht Club in Cambridge, MD

This conference is for members in Worcester, Somerset, Dorchester, Wicomico, Talbot, Caroline, Queen Anne's, Kent, and Cecil counties and is intended to address the concerns of physicians on Maryland's Eastern Shore. A one-hour continuing medical education program will be presented at this conference. For more information, contact Joan Mannion at 410-539-0872 or 1-800-492-1056.

3. "Third Annual Conference on Addiction: Physician Health and Education"

Saturday, November 21, 1992 from 7:30 a.m. to 6:15 p.m.

at the Med Chi Faculty Building, 1211 Cathedral Street, Baltimore, MD

Sponsored by the Med Chi Physician Rehabilitation Committee and the Committee on Scientific Activity, this conference will feature sessions on prescription drug abuse, litigation stress, and the effect of tobacco on psychotropic medications. Plenary sessions will address the following topics: What is addiction, patient placement criteria manual, identification and treatment of the substance-abusing patient, and an update on how to help your patients stop smoking. A preliminary program for this meeting appears on pages 846-847 of this *Maryland Medical Journal*.

4. 1993 Med Chi Annual Meeting

April 30 - May 1, 1993

at the University of Maryland University College Conference Center in College Park, MD

Watch the Executive Director's Newsletter for more information about this meeting.

Membership Survey

In an effort to improve the services offered to its members, Med Chi sent a membership survey to over 1,800 physicians in August. The survey is intended to ascertain physician attitudes about Med Chi benefits, as well as survey physician opinions about a number of health care issues. If you have already mailed back your survey, Med Chi appreciates your assistance. If you received a survey and have not completed it yet, Med Chi will send you a second, reminder survey in the next few weeks. Please complete and return it to Med Chi as soon as possible. For questions regarding the survey, please contact Sandy Heim at 410-539-0872 or 1-800-492-1056.

*Med Chi Committee
Handbook 1992-1993*

The 1992-1993 *Handbook of the Medical and Chirurgical Faculty of Maryland* will be available for Med Chi physicians on September 21, 1992. The *Handbook* is a valuable tool for any member of Med Chi and features listings of

- Med Chi officers,
- Members of the House of Delegates,
- Members of Med Chi's more than 40 committees,
- Med Chi staff contacts,
- Component medical society officers,
- Specialty society officers, and
- Gubernatorial appointments.

Med Chi members may order their complimentary copy of the *Handbook* by calling the Communications Department at 410-539-0872 or 1-800-492-1056. Additional copies of the *Handbook* are available at the nonmember price of \$25.00.

*Flu/Radon Brochures
Available from the
American Lung
Association*

The American Lung Association (ALM) is offering free copies (while supplies last) of two physician newsletters entitled *Influenza News* and *Pneumonia News*, as well as posters encouraging patients to get a flu shot.

To help educate physicians about the damaging effects of radon in the home, the ALM also offers a free brochure, *Radon, A Physician's Guide*.

To order either of these publications, call the American Lung Association of Maryland at 1-800-492-7527.

*AMA National Political
Education Conference*

The American Medical Association (AMA) will be sponsoring a National Political Education Conference on September 29-30, 1992 at the Hyatt Regency in Washington, DC. For more information about this conference, contact Nancy Warren in the AMA's DC office at 202-789-7465.

*Physician Volunteers for
Hurricane Relief*

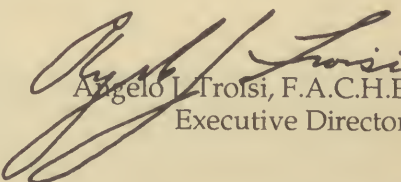
The Florida Medical Association (FMA) is accepting names of physicians interested in volunteering their services for the hurricane relief effort in Florida. Interested physicians should send their

- Name,
- Address,
- Telephone number (day and evening),
- Medical specialty, and
- Dates available for service.

The letter should also indicate whether you can provide for your own housing and what types of personal medical equipment you can bring with you. FMA will respond to all letters sent to the following address:

Florida Medical Association
760 Riverside Avenue
Jacksonville, FL 32203
Attn: Karloyn Mallarnee

Physicians concerned about medical relief efforts in areas of Louisiana should note that the Louisiana Medical Association has stated that it has adequate medical assistance available.


Angelo L. Troisi, F.A.C.H.E.
Executive Director

Minutes of the House of Delegates—336th Meeting—April 30, 1992

The 336th meeting of the House of Delegates of the Medical and Chirurgical Faculty was held on Thursday, April 30, 1992 in the Liberty Room of the Omni Hotel in Baltimore. Officers present were J. David Nagel, M.D., president; Jose M. Yosuco, M.D., president-elect; Carol W. Garvey, M.D., secretary; Albert L. Blumberg, M.D., treasurer; Marvin Schneider, M.D., first vice-president and chairperson of Council; Alex Azar, M.D., third vice-president; and Reynaldo L. Lee-Llacer, M.D., immediate past president.

Allegany

Delegates

Victor R. Felipa, M.D.
Frederick Miltenberger, M.D.

Councilor

Leslie R. Miles, M.D.

Anne Arundel

Delegates

Richard A. Bernstein, M.D.
*Leoncio A. Ceccarelli, M.D.*²
Candace I. Chandler, M.D.
Astrida P. Turkopuls, M.D.

Councilor

Hilary T. O'Herlihy, M.D.

Baltimore City

Delegates

Donald M. Barrick, M.D.
Paul Burgan, M.D.
*Nijole B. Carozza, M.D.*¹
Donald C. Chambers, M.D.
Beverly A. Collins, M.D.
Augusto R. DeLeon, M.D.
K. George Dritsas, M.D.
Willarda V. Edwards, M.D.
Albert Folgueras, M.D.
Frank A. Giargiana, Jr., M.D.
Ronald L. Gutberlet, M.D.
Rafael C. Haciski, M.D.
Thomas E. Hunt, M.D.
*John Josselson, M.D.*¹
John B. MacGibbon, M.D.
Raymundo S. Magno, M.D.
Donald W. Mintzer, M.D.
Samuel I. O'Mansky, M.D.
Stephen K. Padussis, M.D.

*William B. Russell, M.D.*¹

Bernard R. Shochet, M.D.

J. Andrew Sumner, M.D.

Karl H. Weaver, M.D.

Joseph W. Zebley, III, M.D.

Jack M. Zimmerman, M.D.

Councilors

James E. Bell, M.D.
Donald H. Dembo, M.D.
Susan R. Guarnieri, M.D.
Joseph H. Hooper, M.D.
Allan D. Jensen, M.D.
Hiroshi Nakazawa, M.D.
Gary L. Rosenberg, M.D.
*Roland T. Smoot, M.D.*³
*Henry N. Wagner, M.D.*³
*Jose M. Yosuco, M.D.*³

Baltimore County

Delegates

*Angelo A. Alecce, M.D.*¹
Ruben F. Ballesteros, M.D.
Marianne Benkert, M.D.
John W. Buckley, M.D.
*Alan S. Davis, M.D.*¹
*Maurice B. Furlong, M.D.*¹
*Scott D. Hagaman, M.D.*¹
Richard M. Hirata, M.D.
Deusdedit L. Jolbitado, M.D.
*Frank T. Kasik, Jr., M.D.*¹
John M. Krager, M.D.
Mayer C. Liebman, M.D.
*Jose Martinez, M.D.*¹
Elsa R. Merani, M.D.
N. Edward Nachlas, M.D.
Ronald J. Orrell, M.D.
Gary W. Pushkin, M.D.
Scott M. Rifkin, M.D.
Sidney B. Seidman, M.D.
Margaret L. Sherrard, M.D.
Edward F. Wenzlaff, M.D.
H. Russell Wright, Jr., M.D.

Councilors

Thomas E. Allen, M.D.
*Albert L. Blumberg, M.D.*³
Harold B. Bob, M.D.
Louis C. Breschi, M.D.
Esther Ederly, M.D.
Abdolhamid H. Ghiladi, M.D.
Christopher Harvey, M.D.
*John H. Hebb, M.D.*³
*J. David Nagel, M.D.*³

Calvert

Councilor

Joseph S. Fastow, M.D.

Caroline

Councilor

Christian Jensen, M.D.

Carroll

Delegate

Daniel I. Welliver, M.D.

Cecil

Delegates

Henry J. Farkas, M.D.
*Andrew P. Fridberg, M.D.*²

Charles

Councilor:

Guillermo E. Sanchez, M.D.

Dorchester

Delegate:

*Paul A. Stagg, M.D.*²

Frederick

Delegate

Arthur G. Manalo, M.D.

Harford

Delegate

Ben Oteyza, M.D.

Howard

Delegates

Emidio Bianco, M.D.
Joyce M. Boyd, M.D.
Melvin S. Rapelyea, M.D.
Charles E. Taylor, M.D.
Brian J. Winter, M.D.

Councilor

Allan T. Leffler, M.D.

Montgomery

Delegates

Benjamin Avrunin, M.D.
Carol L. Bender, M.D.
*Christine D. Berg, M.D.*¹
Larry M. Einbinder, M.D.
Ralph E. Longway, M.D.
Mark E. Mausner, M.D.
Edward S. Mehlman, M.D.
Bruce E. Rubin, M.D.
Philip L. Schneider, M.D.
Mark S. Seigel, M.D.
*Peter Sherer, M.D.*¹
Margaret T. Snow, M.D.
Eugene K. Sussman, M.D.
Stephen G. Vaccarezza, M.D.
Vincent J. Vaghi, M.D.

¹ Alternate delegate

² Delegate serving both as councilor and delegate for component society

³ Elected officer or AMA delegate

Minutes of the House of Delegates

*Isaac Weiszer, M.D.*¹
Stephen W. White, M.D.

Councilors

*Carol W. Garvey, M.D.*³
Barton J. Gershen, M.D.
Fred A. Gill, M.D.
Herman C. Maganzini, M.D.
Francis C. Mayle, Jr., M.D.
*Marvin Schneider, M.D.*³
Donald S. Stepita, M.D.

Prince George's

Delegates

Brian S. Bayly, M.D.
James S. Chesley, M.D.
Said A. Dae, M.D.
Riad Dakheel, M.D.
Suresh C. Gupta, M.D.
John E. Jeffrey, M.D.
Zorayda M. Lee-Llacer, M.D.
*Benjamin Maldonado, M.D.*¹
George S. Malouf, Jr., M.D.
David N. Robb, M.D.
Elie A. Sayan, M.D.

Councilors

Willie C. Blair, M.D.
Nelson G. Goodman, M.D.
*Reynaldo L. Lee-Llacer, M.D.*³
J. Richard Lilly, M.D.
*George S. Malouf, Sr., M.D.*³

St. Mary's

Delegate

*J. Roy Gnyther, M.D.*²

Talbot

Councilor

*Donald T. Lewers, M.D.*³

Washington

Delegate

Edward W. Ditto III, M.D.

Councilor

Francisco G. Japzon, M.D.

Wicomico

Delegate

*Hilda I. Honlihan, M.D.*²

Councilor

Alex Azar, M.D.

Worcester

Delegate

*Federico G. Arthes, M.D.*²

Resident

Councilor

Eric Lon Shampaine, M.D.

Student

Delegate

*W. David Sullivan*²

Specialty Societies

Delegates

James Castellano, M.D.

Jay Gerstenblith, M.D.
Christian S. Mass, M.D.
Richard B. Williams, M.D.

Councilor

Kenneth B. Lewis, M.D.

Deans of Maryland Medical Schools

Councilor

Donald E. Wilson, M.D.

The following past presidents, some of whom are delegates, were present: Raymond M. Atkins, M.D.; Robert L. Campbell, M.D.; John R. Davis, Jr., M.D.; DeWitt E. DeLawter, M.D.; Michael R. Dobridge, M.D.; J. Roy Guyther, M.D.; Arthur T. Keefe, Jr., M.D.; Donald T. Lewers, M.D.; George S. Malouf Sr., M.D.; Francis C. Mayle, Jr., M.D.; and Roland T. Smoot, M.D.

Also present were the following executive directors: Neilson Andrews, Baltimore County; Diane Briggs, Prince George's County; Bernadette Lane, Baltimore City; and Edward Shanbacker, Montgomery County. The Faculty's executive director, Angelo J. Troisi, F.A.C.H.E., was present, as well as other members of the Faculty's staff including Joseph Harrison, associate executive director; Rose M. Matricciani, R.N., J.D., assistant executive director for healthcare policy; and Carmine M. Valente, Ph.D., deputy executive director.

Call to Order

The first session of the House of Delegates for the 1992 Med Chi Annual Meeting was called to order at 9:50 a.m. on Thursday, April 30, 1992 in the Liberty Room of the Omni Hotel in Baltimore by President J. David Nagel, M.D.

Invocation

Leslie R. Miles, Jr., M.D., chairperson of the Committee on Medicine and Religion, delivered the invocation.

Visiting Dignitaries

Dr. Nagel recognized the visiting dignitaries who were present at this session and others who would be joining us during the annual meeting, including Stephen R. Permut, M.D.,

president-elect, Delaware; John W. Hollowell, M.D., president, Virginia; Constantiano Amores, M.D., president, West Virginia; Roselyn Epps, M.D., president, Washington, DC; Joseph A. Riggs, M.D., president, New Jersey; Thomas Reardon, M.D., AMA/trustee; The Honorable Kevin Moley, deputy secretary, Department of Health and Human Services; Senator Thomas V. "Mike" Miller (Maryland Senate); Ebba Dunn and Carole Loughheed, AMA Auxiliary; Vivian Lynn and Elizabeth Lindhardt, Med Chi Auxiliary; and Ronald Shapiro, Esq.

Minutes from Semiannual Session

The minutes from the September 14, 1991 meeting of the House of Delegates were approved as written.

George M. and M. McKendree Boyer Memorial Lectureship

The George M. and M. McKendree Boyer Memorial Lectureship was presented by Ronald Shapiro, Esq., who spoke on "Successful Negotiations and Communication."

After the presentation, Dr. Nagel introduced Mrs. Helen Boyer, widow of the late Dr. M. McKendree Boyer in whose name the memorial lectureship was presented. The House of Delegates gave a round of applause to Helen Boyer.

Dr. Nagel then presented Ronald Shapiro, Esq. with a Med Chi certificate of appreciation along with the Drs. Boyers' honorarium, which Mr. Shapiro graciously donated to the University of Maryland Cancer Center.

Deceased Members

The secretary, Carol W. Garvey, M.D., read the list of deceased members.

Anne Arundel

Cenap S. Dorkan, M.D.

Date not available

Charles Milton Linthicum, M.D.

November 23, 1991

Baltimore City

Robert M. Bamhart, M.D.

July 22, 1991

Albert B. Bradley, M.D.
February 10, 1992
John W. Chambers, M.D.
October 3, 1991
Bernard J. Cohen, M.D.
October 22, 1991
Beverly C. Compton, M.D.
October 11, 1991
R. Adams Cowley, M.D.
October 27, 1991
Herman J. Dorf, M.D.
February 12, 1990
Theodore J. Graziano, M.D.
November 30, 1991
Donald B. Hebb, M.D.
January 16, 1992
Eliot W. Johnson, M.D.
August 30, 1991
James R. Karns, M.D.
February 28, 1992
Samuel Legum, M.D.
July 13, 1991
Charlotte McCarthy, M.D.
February 4, 1992
William J. McClafferty, Jr., M.D.
July 28, 1991
Robert S. Sardo, M.D.
October 19, 1991
George Sharfatz, M.D.
September 1, 1987
J. Frank Snpplee III, M.D.
August 21, 1991
Kennard L. Yaffe, M.D.
December 4, 1991

Baltimore County

William T. Dixon, M.D.
October 22, 1991
Gerald A. Galvin, M.D.
November 15, 1991
William Goodman, M.D.
May 22, 1991
D. Crosby Greene, M.D.
November 30, 1991
Hugh B. McNally, M.D.
May 24, 1991
Andrew C. Montague, M.D.
October 5, 1991
Evelyn J. Nelson, M.D.
April 3, 1991
John S. O'Connor, M.D.
September 3, 1991
Robert Ronbenoff, M.D.
September 10, 1991
Samuel Stern, M.D.
February 23, 1992
Stephen Toms, M.D.
November 18, 1991

Carroll County

Jose L. Chapulle, M.D.
December 4, 1991
Robert S. McVaugh, M.D.
July 30, 1991

Cecil County

Milton Ginsberg, M.D.
March 17, 1992

Frederick County

Martha T. Schipper, M.D.
January 22, 1992

Montgomery County

Henry E. Andren, M.D.
March 21, 1991
Erich Heydt, M.D.
September 3, 1991
Oscar B. Hunter, Jr., M.D.
September 21, 1991
William H. Killay, M.D.
July 10, 1991
William A. Linthicum, M.D.
July 25, 1991
Richard E. Lukes, M.D.
January 28, 1992
Ralph F. Patten, M.D.
May 16, 1991
Carolyn H. Pincock, M.D.
October 30, 1991
Richard M. Schisgall, M.D.
April 20, 1991
Kenneth A. Simon, M.D.
February 13, 1992
Lysle W. Williams, M.D.
Date not available

Prince George's County

Hugh G. Clark, M.D.
March 30, 1991
Benjamin S. Miller, M.D.
May 21, 1991

Washington County

Sidney Novenstein, M.D.
November 21, 1991

Wicomico

Paul G. Cayaves, M.D.
July 28, 1991
James P. Gallaher, M.D.
January 9, 1991

Affiliates

Oswald Berrios, M.D.
May 29, 1991
Norman N.K. Katz, M.D.
August 10, 1991
Antonio Palladino, M.D.
June 1, 1991
George M. Simons, M.D.
May 15, 1991

After the reading of the list of deceased members, the House of Delegates paused for a moment of silence.

Memorial Resolutions

Dr. Garvey reported the following

memorial resolutions, which were adopted by the House of Delegates:

Richard M. Schisgall, M.D. 1931-1991

Whereas Richard M. Schisgall, M.D., a native of New York City, received his medical degree from New York University, interned at Bellevue Hospital, and underwent residency training in surgery at Bellevue Hospital and in pediatric surgery at Children's Hospital, Detroit, Michigan; and

Whereas he began his practice of pediatric surgery in Montgomery County, and

Whereas Dr. Schisgall served devotedly as a physician to children, as a kind and lucid teacher to young surgeons trained under him, and as a skilled and responsive colleague for his fellow professionals; and

Whereas he shared his knowledge through articles published on such common pediatric surgical problems as acute appendicitis, appendiceal colic, hernias, and the management of hydroceles; and

Whereas he elucidated for contemporary and future surgeons the previously poorly understood entity of appendiceal colic, thus relieving recurrent abdominal pain in scores of children through a simple operation; and

Whereas his death has left a very real void in the lives of his family, friends, patients, and colleagues;

Therefore, Be it resolved, that this House of Delegates of the Medical and Chirurgical Faculty of Maryland on April 30, 1992 adopts this resolution with an expression of profound sorrow on the death of Dr. Schisgall; and be it further

Resolved, That this resolution be spread upon the minutes of this meeting and a copy be sent to his wife, Harriet, in recognition of the high esteem in which Dr. Schisgall was held and will be remembered.

Benjamin Sidney Miller, M.D. 1910-1991

Whereas Benjamin Sidney Miller, M.D. was born in Brooklyn, New York

where he was educated until graduating from Boys High School in 1927. He traveled to Little Rock to pursue his undergraduate degree at the University of Arkansas.

Whereas Dr. Miller graduated from the University of Arkansas School of Medicine in 1934 and interned at Brooklyn Jewish Hospital. After practicing briefly in New York and serving as an Army physician in Europe during World War II, Dr. Miller opened his office for the practice of family medicine in Mt. Ranier in 1947.

Whereas Dr. Miller is notable for his extraordinary contributions to the Prince George's County Medical Society, serving as president in 1955. During his tenure in that capacity, Dr. Miller was instrumental in starting the county program in which elementary school children were inoculated with the Salk polio vaccine.

Whereas Dr. Miller had a long and distinguished career which included serving as resident of the Medical Staff of Prince George's General Hospital from 1961 to 1963. His dedication to his patients was exemplary and remained evident until his retirement from practice in 1980.

Whereas his death will leave a very real void in the lives of his family, friends, former patients, and colleagues; therefore, be it

Resolved, That this House of Delegates of the Medical and Chirurgical Faculty of Maryland on April 30, 1992 adopts this resolution with an expression of profound sorrow on the death of Dr. Miller; and be it further

Resolved, That this resolution be spread upon the minutes of this meeting and a copy sent to his daughters Wendy Miller and Deborah Miller Glasberg in recognition of the high esteem in which Dr. Miller was held and will be remembered.

Charles Milton Linthicum, M.D. 1922-1991

Whereas Charles Milton Linthicum, M.D. was born December 11, 1922. He received his medical degree from the University of Maryland in 1945, served in the United States Air

Force as captain and military flight surgeon.

Whereas Dr. Linthicum opened his general practice in 1953 in Linthicum, a town founded by his grandfather. Dr. Linthicum left a legacy of dedicated interest and rapport with his general practice patients.

Whereas Dr. Linthicum later changed his specialty to pathology. In 1963 he became chief of pathology for the Chronic Disease Hospitals (Montebello, Western Maryland, and Eastern Shore). He also served as a pathologist at Mt. Wilson State, Johns Hopkins, St. Joseph's, and Maryland General Hospitals in Maryland, and Norwalk Hospital in Connecticut.

Whereas Dr. Linthicum enjoyed travel, he once served as ship's surgeon on the SS United States. However, most important to Dr. Linthicum were his sons, and he always managed his schedule so that he was instrumental in their upbringing. Always active in community affairs, he served as a member of various boards.

Whereas Dr. Linthicum's death will leave a real void in the lives of his family, his wife Verena, children Reverend James Douglas Linthicum and Robert Edward Linthicum, his friends, former patients, constituents, and colleagues; therefore, be it

Resolved, That this House of Delegates of the Medical and Chirurgical Faculty, on April 30, 1992, adopts this resolution with an expression of profound sorrow on the death of Dr. Linthicum; and be it further

Resolved, That this resolution be spread upon the minutes of this meeting and a copy sent to his wife, Verena, in recognition of the high esteem in which Dr. Linthicum was held and will be remembered.

Cenap S. Dorkan, M.D. 1928-1991

Whereas Cenap S. Dorkan, M.D. was born in Istanbul, Turkey, September 13, 1928. He received his medical degree from the University of Istanbul in 1956, served a residency and internship in Harrisburg, Pennsylvania and Minneapolis, Minnesota, and was an

instructor of internal medicine for the Department of Medicine, University of Istanbul, from 1961 to 1963.

Whereas Dr. Dorkan in 1961 began his practice in Maryland and joined the Anne Arundel County Medical Society in 1967. He served as president of the society in 1980, was director of the society, and was a delegate to the Medical and Chirurgical Faculty of Maryland, as well as a councilor from 1981 to 1984.

Whereas Dr. Dorkan will be remembered as a dedicated caring physician whose primary concern was the welfare of his patients. Dr. Dorkan had a deep appreciation of music, was an avid theater buff, and friends recall his interest in photography and cars. However, his greatest pleasure was to relax aboard his boat.

Whereas Dr. Dorkan's death will leave a very real void in the lives of his family, his wife Linda, his children Jale and Murat, his friends, his former patients, his constituents, and his colleagues; therefore, be it

Resolved, That this House of Delegates of the Medical and Chirurgical Faculty, on April 30, 1992, adopts this resolution with an expression of profound sorrow on the death of Dr. Dorkan; and be it further

Resolved, That this resolution be spread upon the minutes of this meeting and a copy sent to his wife, Linda Dorkan, in recognition of the high esteem in which Dr. Dorkan was held and will be remembered.

Kennard L. Yaffe, M.D. 1913-1991

Whereas Kennard L. Yaffe, M.D., a native Baltimorean who devoted his life to serving Baltimore's citizens and his profession, died on December 4, 1991; and

Whereas Dr. Yaffe received his B.Sc. in pharmacy from the University of Maryland in 1934 and his M.D. from the University of Maryland School of Medicine in 1938; and

Whereas Dr. Yaffe entered the private practice of general medicine in 1940 and continued in that practice until March 1991; and

Whereas Dr. Yaffe was an active member of the Baltimore City Medical Society and the Medical and Chirurgical Faculty during his entire career; and

Whereas Dr. Yaffe served the Baltimore City Medical Society in a number of committee positions, including the Peer Review Committee, and as a member of the Board of Directors, treasurer and vice-president, before his election as president in 1983; and

Whereas Dr. Yaffe served the Medical and Chirurgical Faculty in many capacities including member of the House of Delegates and Executive Council, chairperson of the Committee on Drugs, and member of the Health Planning Committee and the Physician Rehabilitation Committee; and

Whereas Dr. Yaffe worked diligently to maintain the quality of medical care delivered in the community and to assure that the control of the practice of medicine remained in the hands of physicians through his work with the Baltimore City Professional Standards Review, the Maryland Foundation for Health Care, and the Central Maryland Health Systems Agency; and

Whereas Dr. Yaffe's friends and family have established a memorial scholarship fund in his honor with the Baltimore City Medical Society (BCMS) Foundation, Inc.; therefore, be it

Resolved, That the Medical and Chirurgical Faculty be encouraged to send contributions to the Kennard L. Yaffe Memorial Scholarship Fund of the BCMS Foundation, Inc., 819 Park Avenue, Baltimore, MD 21201; and be it further

Resolved, That this resolution be spread upon the minutes of this meeting and a copy be sent to Dr. Yaffe's wife and family in recognition of the high regard in which Dr. Yaffe was held by his colleagues and friends.

Henry P. and Page Laughlin Award for Citizenship

The president, Dr. Nagel, presented the "Dr. Henry P. and Page Laughlin

Award for Citizenship" to the president of the Maryland Senate, the Honorable Thomas V. "Mike" Miller. Senator Miller stated that he was surprised on winning this award; he thought he was here only to present citations to Med Chi members. He mentioned that in his dealings with Med Chi, he has noted how the Faculty focuses on the image of the profession.

Citations and Proclamations

On behalf of the governor, Senator Miller presented President J. David Nagel, M.D. with a citation and proclamation for his efforts during his term as president of the Faculty.

Senator Miller also presented to the Faculty a citation for outstanding contributions to medicine during the past year.

Senator Miller presented George S. Malouf, Sr., M.D., recipient of the AMA's Benjamin Rush Award, with the Governor's Salute for Excellence.

A citation was also presented to Albert Blumberg, M.D. for his work as chairperson of the Legislative Committee.

Recognition of Dean Emeritus Dennis and Dean Wilson

The June 1992 issue of the *Maryland Medical Journal (MMJ)* will commemorate the retirement of John Dennis, M.D. as dean of the University of Maryland School of Medicine, and the December 1991 issue of the *MMJ* commemorated Donald Wilson, M.D. taking over as dean. Both Dean Emeritus Dennis and Dean Wilson were presented with framed copies of the respective *MMJ* covers by President J. David Nagel, M.D. and by the editor of the *MMJ*, Victor R. Hrehorovich, M.D.

AMA-ERF Checks

President J. David Nagel, M.D. asked the president of the Faculty's Auxiliary, Vivian Lynn, and the Auxiliary's chairperson for the AMA-ERF (American Medical Association Education and Research Foundation),

Elizabeth Linhardt, to come forward to present the AMA-ERF checks to the three Maryland medical schools.

Contributions to the AMA-ERF fund in 1991 totaled more than \$31,345, of which \$24,040 was contributed by Med Chi members.

The Johns Hopkins University School of Medicine received checks for \$12,385 in unrestricted funds for the Johns Hopkins Medical School Excellence Program and a check for \$6,070 in restricted funds for the Medical Student Assistance Program. Roland Smoot, M.D. accepted the checks on behalf of the university.

The Uniformed Services University of the Health Sciences, Henry M. Jackson Foundation, received two checks totaling almost \$500. Mr. Charles L. Duffney, counsel to the foundation, accepted the checks on behalf of the university.

The University of Maryland School of Medicine received checks for \$20,395 in unrestricted funds for the medical school's Excellence Program and \$9,027 in restricted funds for the medical school's Student Assistance Program. Dean Donald E. Wilson, M.D. accepted the two checks on behalf of the university.

Fifty-Year Certificates

President J. David Nagel, M.D. presented the following physicians with fifty-year certificates:

Baltimore City

Edward F. Cotter, M.D.
Everett S. Diggs, M.D.
James Frenkil, M.D.
Harold V. Harbold, M.D.
Walter E.E. Loch, M.D.
George Merrill, M.D.
S.G. Sullivan, M.D.
Harry A. Teitelbaum, M.D.

Cecil County

S. Ralph Andrews, Jr., M.D.

Dr. Nagel noted that the following physicians, who are fifty-year members, were not able to attend today's presentation:

Allegany

Ralph W. Ballin, M.D.

Abraham J. Mirkin, M.D.

Anne Arundel

E.J. Mulligan, M.D.

Baltimore City

Gilbert W. Benjamin, M.D.

Harry C. Bowie, M.D.

Walter B. Buck, M.D.

Arnold L. Field, M.D.

Wilson L. Grubb, M.D.

Howard B. Mays, M.D.

Conrad L. Richter, M.D.

Paul W. Roman, M.D.

Montgomery

Philip H. Varner, M.D.

Affiliate

Douglas H. Stone, M.D.

Wyeth-Ayerst Laboratories Physician Award

The Wyeth-Ayerst Laboratories Physician Award, which is presented each year to a physician who has provided outstanding service to his or her community outside the field of medicine, was presented to Clifford Andrew, M.D. by President J. David Nagel, M.D.

Dr. Nagel noted that Dr. Andrew is a leader in the Severn River Association and that his activities have been aimed at local environmental protection, which led to the Severn River Association being used as a model for other river associations along the Chesapeake Bay. Because of Dr. Andrew's efforts, the Severn River Association has been awarded several major conservation awards. Dr. Andrew has devoted countless hours to the protection of Anne Arundel County's natural resources.

Certificates of Recognition to Committee Chairpersons

The following three physicians were presented with certificates of recognition for their outstanding service and dedication as chairpersons of Med Chi committees by President J. David Nagel, M.D.:

Edward J. Kowalewski, M.D.

Chairperson, Focused

Professional Education Committee

Hiroshi Nakazawa, M.D.

Chairperson, Public Relations
Committee

Ronald J. Cohen, M.D.

Chairperson, Peer Review

Management Committee

Photo Contest

President J. David Nagel, M.D. stated that the winners of the 12th Annual Photo contest were *Michael A. McClinton, M.D.*, first place; and *David Paul, M.D.*, second place.

Dr. Nagel congratulated the winners and stated that their awards had been provided to them.

AMPAC Award

Samuel Gelfand, M.D. of the American Medical Political Action Committee (AMPAC) presented J. David Nagel, M.D. and John Lynn, M.D. of the Maryland Medical Political Action Committee (MMPAC) with an award; MMPAC was the national second place winner for its increase in AMPAC membership. Dr. Gelfand stated that he hoped he would be able to present the first place award to the Faculty next year.

Emeritus Membership

J. David Nagel, M.D., president, called on Marvin Schneider, M.D., chairperson of Council, for presentation of the emeritus members to the House of Delegates. Dr. Schneider made a motion to dispense with the reading of the list of emeritus members. The motion was seconded and passed. The following members were granted emeritus membership:

Anne Arundel County

Steven J. Abramedis, M.D.

Antonio L. Kison, M.D.

Joseph Taler, M.D.

Baltimore City

B. Stanley Cohen, M.D.

R. Donald Eney, M.D.

William F. Fritz, M.D.

Socrates I. Kendros, M.D.

Raymond E. Knowles, M.D.

Baltimore County

William G. Esmond, M.D.

David J. Gillis, M.D.

John B. Hearn, M.D.

Enrique A. Herrera, M.D.

Daniel F. Johnston, M.D.

Frank G. Kuehn, M.D.

Joseph E. Schulte, M.D.

Dick W. Wei, M.D.

Frederick County

Henry L. McCorkle, M.D.

Harford County

Miguel J. Mayol, M.D.

Howard County

Anthony Jean-Jacques, M.D.

Montgomery County

Nasser H. Bahraini, M.D.

John H. Bouma, M.D.

John A. Dowling, M.D.

Robert M. Greenberg, M.D.

James P. Hartley, M.D.

Abdul S. Hashim, M.D.

Daniel L. Hayes, M.D.

Rene A. Llera, M.D.

Bennet A. Porter, M.D.

Yasuo Takahashi, M.D.

Prince George's County

Victor S. Chupkovich, M.D.

David S. Gordon, M.D.

Patricia M. Shaughnessy, M.D.

St. Mary's County

Juanito C. Roa, M.D.

Wicomico County

Peter R. Boolukos, M.D.

Charles R. Derrickson, M.D.

Stephan Tymkiw, M.D.

William F. Van de Graaff, M.D.

Affiliate Members

Carla A. Cuccia, M.D.

Ernest A. Dettbarn, M.D.

Council Report

J. David Nagel, M.D., president, asked the chairperson of Council, Marvin Schneider, M.D., if he had a further report to present to the House of Delegates. Dr. Schneider summarized the Council and Executive Committee highlights from September 1991 to April 1992 and noted that reports were available in the back of the room.

In his summary, Dr. Schneider discussed

- BC/BS Provider Journal—Council voted to oppose the "Date of Onset" issue
- Substance abuse in the workplace—Council approved policy supporting individual hospital re-

sponsibility for drug testing of physicians.

- **HIV**—The Council passed the protocol for physicians testing positive for HIV, which was presented to the Maryland legislature in December. The Executive Committee also approved a series of three letters for the education of legislators and the public regarding mandatory HIV testing.
- **Living Will and Power of Attorney**—Council approved that one copy of this pamphlet be provided to each physician member.
- **Physician-patient communication**—The Council adopted the AMA's position opposing the federal government's restriction on physician-patient communication on family planning options as an intrusion on the practice of medicine.
- **Laboratory regulations**—The Executive Committee approved devoting a section of the annual meeting to education on laboratory regulations.
- **International medical graduates (IMGs)**—The Executive Committee supported IMGs and testified on behalf of IMGs at the BPQA and in the Maryland Legislature.
- **Medicine and performing arts seminar**—The Council approved a two-day conference on medicine and the performing arts, which was held at Med Chi on January 24-25, 1992 and which was successful.
- **Healthcare Credentials Verification (HCV)**—The Maryland Hospital Association and Med Chi ceased operations of HCV. Dr. Schneider mentioned that the credentialing material was locked up at Med Chi.

The president thanked Dr. Schneider for his report.

Bylaws Report

Reynaldo L. Lee-Llacer, M.D., chairperson of the Bylaws Committee, presented the committee's report and recommended adoption of all recom-

mendations. He noted that there were ten items and that two of those items, #2 and #8, had more than one part, and both of these items must be taken as a single package.

After the report was presented, the House of Delegates extracted items #2, #3, and #7.

The report was as follow: [] indicate deletion; CAPS indicate change

1. Proposed bylaw amendment to the PREAMBLE—PURPOSES OF THE SOCIETY

Rationale—Add verbiage for better clarification.

Amend Preamble as follows:

The Faculty is a non-profit organization. The purpose of this Faculty shall be as a non-profit organization to federate and bring into one compact society the medical profession of the State of Maryland, and to unite with similar societies of other states to form the American Medical Association; to extend medical knowledge, [and] advance medical science AND UPHOLD MEDICAL ETHICS; to elevate the standard of medical education and secure the enactment of just laws relating to the practice of medicine and the public health; to foster friendly relations among physicians; and to enlighten and direct public opinion so that the profession shall become more useful in the prevention of disease, in prolonging and adding comfort to life and in promoting a satisfactory distribution of medical care to the citizens of Maryland.

The amendment was adopted by the House of Delegates.

2.(A) Proposed bylaw amendment to ARTICLE III—FINANCE, SECTION 2

Rationale—Delete all reference to annual dues fees in the bylaws. Dues should be a matter of policy as opposed to a standing order within the bylaws.

Amend Article III, Section 2, by deleting the following:

[Section 2. Annual dues shall be:

- (a) *For active members:* \$110.00 for the first year in private practice; \$125.00 for the second year in pri-

vate practice; \$230.00 annually thereafter.

(b) *For associate members:* \$75.00

(c) *For affiliate members:* \$50.00 for those described in Article II, Section 3(1) and (2).

(d) *For student members* and active members who are on the resident staff of hospitals or holding a fellowship: \$5.00.

(e) All other classes of membership shall not be required to pay dues.]

The amendment was adopted by the House of Delegates.

2.(B) Was extracted, presented and amended as follows:

Amend Article III, Section 2, by adding the following:

SECTION 2. ANNUAL DUES SHALL BE ASSESSED TO THE MEMBERS. THE DUES AMOUNTS WILL BE DETERMINED BY THE COUNCIL.

A motion was made, seconded, and passed to add after Council:

AND RATIFIED BY THE HOUSE OF DELEGATES.

The amendment to the amendment was adopted. The amendment was adopted by the House of Delegates.

The final version as adopted reads as follows:

ARTICLE III, SECTION 2. ANNUAL DUES SHALL BE ASSESSED TO THE MEMBERS. THE DUES AMOUNTS WILL BE DETERMINED BY THE COUNCIL AND RATIFIED BY THE HOUSE OF DELEGATES.

2. (C) Proposed bylaw amendment to ARTICLE II—MEMBERSHIP, SECTION 5, SECTION 6, AND SECTION 7

Rationale—With the amendment to Article III, Section 2, the following statement is added to Article II—Membership, for clarification of payment of dues for emeritus members.

Amend Article II, Section 5, 6, and 7, as follows:

Section 5. ...They shall have the rights accruing to associate members AND SHALL NOT BE REQUIRED TO PAY DUES. They shall not be...

Section 6. ...They shall have the rights

accruing to active members AND SHALL NOT BE REQUIRED TO PAY DUES. Forty-year members who...

Section 7. ...The title shall be conferred for life and shall carry with it none of the obligations of membership, INCLUDING NO REQUIREMENT TO PAY DUES. They shall have the rights...

The amendment was adopted by the House of Delegates.

3. Proposed bylaw amendment to ARTICLE III—FINANCE, SECTION 10 was extracted, presented, and amended as follows:

Rationale—To allow disbursement to be made during the first several weeks in the new operational year from an "approved" operating budget.

Amend Article III, Section 10, as follows:

Section 10. [The control of] All funds and investments shall be in the Treasurer who shall present a budget to the [first meeting of the Council held after January 1 each year for its approval.] COUNCIL DURING ITS LAST REGULARLY SCHEDULED MEETING OF THE YEAR PRECEDING THE OPERATING YEAR. When approved, the budget shall act as the Treasurer's authority to expend funds not in excess of amounts described therein for the purposes set forth. Expenditures of funds in excess of, or not provided for, in the budget shall be made only upon the order of the Council or House of Delegates.

After discussion, the chairperson of the Bylaws Committee accepted a revision of the amendment to be presented to the House of Delegates: "The control of" would remain part of Section 10.

The amendment was adopted as follows:

SECTION 10. THE CONTROL OF ALL FUNDS AND INVESTMENT SHALL BE IN THE TREASURER WHO SHALL PRESENT A BUDGET TO THE COUNCIL DURING ITS LAST REGULARLY SCHEDULED MEETING OF THE YEAR PRECEDING THE OPERATING

YEAR. WHEN APPROVED, THE BUDGET SHALL ACT AS THE TREASURER'S AUTHORITY TO EXPEND FUNDS NOT IN EXCESS OF AMOUNTS DESCRIBED THEREIN FOR THE PURPOSES SET FORTH. EXPENDITURES OF FUNDS IN EXCESS OF, OR NOT PROVIDED FOR, IN THE BUDGET SHALL BE MADE ONLY UPON THE ORDER OF THE COUNCIL OR HOUSE OF DELEGATES.

4. Proposed bylaw amendment to ARTICLE XI—COMMITTEES, SECTION 22—A Committee on Mental Health

Rationale—Organizations on the national, state and local levels have condensed, into one organization, those bodies which deal with alcoholism and drug abuse issues, thus creating departments of substance abuse. The committee bylaws are being changed to reflect the same.

Amend Article XI, Section 22, as follows:

Section 22. A Committee on Mental Health of at least five members shall [investigate, consider and] advise upon all areas of emotional and mental health and maintain close liaison with [the areas] ORGANIZATIONS CONCERNED WITH [of] mental retardation and [alcoholism] SUBSTANCE ABUSE.

The amendment was adopted by the House of Delegates.

5. Proposed bylaw amendment to ARTICLE VII, SECTION 9—COUNCIL

Rationale—Component societies should develop their own criteria for the selection of their representative councilor(s).

Amend Article VII, Section 9 as follows:

Section 9. One-third of the *Councilors* shall be selected annually by the component societies from among their active and forty-year members. [who have had some previous active service at the component at Faculty level.] Each component society shall be ...

The amendment was adopted by the House of Delegates.

6. Proposed bylaw amendment to ARTICLE XI - COMMITTEES

Rationale—To make the Ad Hoc Committee on Women in Medicine a standing committee of the Faculty.

Amend Article XI, Section 41 (new), as follows:

SECTION 41. A COMMITTEE ON WOMEN IN MEDICINE OF AT LEAST FIVE MEMBERS SHALL BE APPOINTED ANNUALLY BY THE PRESIDENT AND MAY BE COMPOSED OF BOTH MALE AND FEMALE PHYSICIAN MEMBERS. THE PRESIDENT SHALL ALSO APPOINT THE CHAIRPERSON. THE PURPOSE OF THE COMMITTEE SHALL BE TO ENCOURAGE THE MEMBERSHIP AND PARTICIPATION OF WOMEN IN THIS SOCIETY AND PROMOTE WOMEN'S HEALTH ISSUES TO THE MEMBERSHIP AND THE PUBLIC.

The amendment was adopted by the House of Delegates.

7. Proposed bylaw amendment to ARTICLE XI—COMMITTEES, SECTION 35—Committee on Scientific Activity, was extracted, presented and amended as follows:

Rationale—To more clearly define the responsibilities and authority of the committee and to emphasize the committee's primary goals to be continuing medical education, as well as to be consistent with other committees that are appointed by the president rather than elected by the House of Delegates.

If this amendment is adopted, it shall be effective immediately and there would be no need for the House of Delegates to elect a sixth member of the committee during this meeting. The president shall consider for committee membership those who have been elected by the House of Delegates in the past, as well as this year's nominees. The president will not be restricted to appointing only six members.

Minutes of the House of Delegates

Amend Article XI, Section 35 as follows:

Section 35. [A Committee on Scientific Activity consisting of the Treasurer ex-officio and six members, one of whom shall be elected at the annual session of the House of Delegates each year for a six-year term, shall prepare and issue a program for General Meetings, provide suitable accommodations for the meetings of the Faculty and have charge of all arrangements. It shall also review and approve and disapprove cosponsorship of scientific programs by the Faculty. The elected member whose term next expires shall be Chairperson. The Maryland State Dental Association shall have the right to elect one associate member of the committee with voice, but without vote.]

A COMMITTEE ON SCIENTIFIC ACTIVITY CONSISTING OF AT LEAST NINE MEMBERS SHALL BE APPOINTED ANNUALLY BY THE FACULTY PRESIDENT, WHO SHALL ALSO APPOINT THE CHAIRPERSON. IN ACCORDANCE WITH THE ESSENTIALS THE ACCREDITATION COUNCIL FOR CONTINUING MEDICAL EDUCATION PROMULGATES FROM TIME TO TIME, THE COMMITTEE SHALL DESIGN, DEVELOP, AND PRESENT SCIENTIFIC ACTIVITIES FOR THE PHYSICIANS OF MARYLAND AND WILL BE RESPONSIBLE FOR ALL EDUCATIONAL ACTIVITIES OF THE FACULTY AND ITS COMMITTEES. THE MARYLAND STATE DENTAL ASSOCIATION SHALL HAVE THE RIGHT TO ELECT ONE ASSOCIATE MEMBER OF THE COMMITTEE WITH VOICE, BUT WITHOUT VOTE.

A motion was made by Louis Breschi, M.D., Baltimore County, seconded and passed to amend the first part of the section as follows:

THE COMMITTEE SHALL CONSIST OF NINE MEMBERS. THE FIRST YEAR THE PRESIDENT SHALL APPOINT NINE MEMBERS, THREE OF WHOM SHALL SERVE ONE YEAR, THREE OF WHOM SHALL SERVE TWO YEARS AND

THREE OF WHOM SHALL SERVE THREE YEARS. THEREAFTER, THE PRESIDENT SHALL APPOINT THREE MEMBERS TO THE COMMITTEE EACH YEAR. THE CHAIRPERSON SHALL BE CHOSEN FROM THE THREE MEMBERS IN THEIR LAST YEAR OF TENURE.

The amendment to the amendment was adopted. The amended amendment was also adopted.

The amended amendment reads as follows:

THE COMMITTEE ON SCIENTIFIC ACTIVITY SHALL CONSIST OF NINE MEMBERS. THE FIRST YEAR THE PRESIDENT SHALL APPOINT NINE MEMBERS, THREE OF WHOM SHALL SERVE ONE YEAR, THREE OF WHOM SHALL SERVE TWO YEARS, AND THREE OF WHOM SHALL SERVE THREE YEARS. THEREAFTER, THE PRESIDENT SHALL APPOINT THREE MEMBERS TO THE COMMITTEE EACH YEAR. THE CHAIRPERSON SHALL BE CHOSEN FROM THE THREE MEMBERS IN THEIR LAST YEAR OF TENURE. IN ACCORDANCE WITH THE ESSENTIALS THE ACCREDITATION COUNCIL FOR CONTINUING MEDICAL EDUCATION PROMULGATES FROM TIME TO TIME, THE COMMITTEE SHALL DESIGN, DEVELOP, AND PRESENT SCIENTIFIC ACTIVITIES FOR THE PHYSICIANS OF MARYLAND AND WILL BE RESPONSIBLE FOR ALL EDUCATIONAL ACTIVITIES OF THE FACULTY AND ITS COMMITTEES. THE MARYLAND STATE DENTAL ASSOCIATION SHALL HAVE THE RIGHT TO ELECT ONE ASSOCIATE MEMBER OF THE COMMITTEE WITH VOICE, BUT WITHOUT VOTE.

8.(A) Proposed bylaw amendment to ARTICLE XII—PHYSICIAN'S DEFENSE—SECTION 2

Rationale—There no longer exists the requirement for the Faculty to retain an attorney for physician's defense cases. Current procedure is that the

individual malpractice insurance company designates a defense attorney who performs the legal functions of these panels.

Amend Article XII, Section 2 as follows:

[Section 2. Physician's Defense cases shall be referred to an attorney-at-law retained by the Council for a term of one year who shall convene and preside at panels for members of the Faculty.]

A panel MAY BE [so] convened TO [shall] generally discuss the member's case and may make recommendations and give opinions regarding it. General counsel for the Faculty shall be available for consultation purposes as an incident to Physician's Defense.

The amendment was adopted by the House of Delegates.

8.(B) Proposed bylaw amendment to ARTICLE XII—PHYSICIAN'S DEFENSE—SECTION 3

Amend Article XII, Section 3 as follows:

[Section 3. The Faculty shall assume all expenses, including legal fees incident to the items contained in Section 2 of this Article; but the Faculty shall assume no other costs, fees, or expenses.]

The amendment was adopted by the House of Delegates.

8.(C) Proposed bylaw amendment to ARTICLE XII—PHYSICIAN'S DEFENSE—SECTION 4

Rationale—Breach of contract, libel, and slander are not considered within the scope of medicine malpractice.

Amend Article XII, Section 4 as follows:

[Section 4.] SECTION 3. The term "medical malpractice" or "malpractice" shall include [all actions in tort, breach of contract, libel and slander, and alleged failure to obtain informed consent which arise out of the practice of medicine. The term shall not include] those causes of action which are [not] insurable risks under a [standard] MEDICAL professional liability insurance policy.

The amendment was adopted by the House of Delegates.

9. Proposed bylaw amendment to ARTICLE VII—COUNCIL—SECTION 12

Rationale—To include an alternate councilor to ensure representation at Council meetings.

Amend Article VII, Section 12 (new) as follows:

SECTION 12. EACH COMPONENT SOCIETY MAY SELECT ALTERNATE COUNCILORS WHO SHALL BE SEATED AT COUNCIL MEETINGS IN THE ABSENCE OF THEIR COMPONENT COUNCILOR(S). SUCH ALTERNATE COUNCILOR(S) MUST BE REPORTED BY THE COMPONENT SOCIETY TO THE FACULTY PRIOR TO THE COUNCIL MEETING. IN NO CASE WILL THE ALTERNATE COUNCILOR(S) PARTICIPATE IN THE DISCUSSIONS AND VOTING OF THE COUNCIL IF THE REGULAR COUNCILOR IS PRESENT. NO COMPONENT SOCIETY SHALL GAIN ADDITIONAL COUNCIL VOTES ABOVE THEIR AUTHORIZED NUMBER BY REASON OF THIS ALTERNATE COUNCILOR(S)' PRIVILEGE.

The amendment was adopted by the House of Delegates.

Discussion ensued regarding when the amendment would become effective. After much discussion, it was decided that the ruling would take effect at the pleasure of the House of Delegates. It was decided that the amendment would take effect Saturday, May 2, 1992 at the next House of Delegates session.

10. Proposed bylaw amendment to ARTICLE XI—COMMITTEES—SECTION 42

Rationale—To make the Ad Hoc Committee on Therapeutic Education a standing committee of the Faculty.

Amend Article XI, Section 42 (new) as follows:

SECTION 42. A COMMITTEE ON THERAPEUTIC EDUCATION OF AT LEAST SEVEN MEM-

BERS SHALL BE APPOINTED BY THE PRESIDENT WHO SHALL ALSO APPOINT THE CHAIRPERSON. THE PURPOSE OF THE COMMITTEE SHALL BE TO DEVELOP INFORMATIONAL AND EDUCATIONAL PROGRAMS FOR PHYSICIANS REGARDING EFFECTIVE AND COST EFFICIENT PRESCRIBING PRACTICES. IT SHALL AID THE MEDICAL ASSISTANCE PROGRAM IN ANALYZING THE EFFECTIVENESS OF "THERAPEUTIC FORMULARIES." THE COMMITTEE WILL ENDEAVOR TO ENSURE THAT ANY PREAUTHORIZATION MECHANISM IS ACCEPTABLE TO MED CHI. THE COMMITTEE MAY COOPERATE WITH AND INVITE GOVERNMENT AND PRIVATE AGENCIES WORKING IN THE PHARMACEUTICAL FIELD AND INVITE THE ATTENDANCE OF PHYSICIANS AND NONPHYSICIAN MEMBERS OF SUCH AGENCIES TO WORK WITH THE COMMITTEE ON A NON-VOTING BASIS.

The amendment was adopted by the House of Delegates.

Treasurer's Report

The treasurer, Albert Blumberg, M.D., stated that the 1992 budget had been approved by Council and that Med Chi is working within the budget.

Nominating Committee Report

The president, J. David Nagel, M.D., asked the chairperson of the Nominating Committee, Reynaldo L. Lec-Llacer, M.D., for the Nominating Committee's report. Dr. Lee-Llacer presented the report as follows:

- For president-elect (president-elect 1992-93) (president 1993-94): *Joseph Snyder, M.D.*
- For Committee on Scientific Activity (6-year term, 1993-1998): *Myron I. Murdock, M.D.*
- For Finney Fund Committee (5-

year term, 1993-1998): *Susan R. Guarnieri, M.D.*

- For delegates to the AMA for the terms January 1, 1993 to December 31, 1995: *Henry N. Wagner, M.D.; Roland T. Smoot, M.D.*
- For alternate delegates to the AMA for the terms January 1, 1993 through December 31, 1995: *Eric Lon Shampaine, M.D. (resident); Herman C. Maganzini, M.D. (student)*
- For Board of Physician Quality Assurance (three vacancies, four-year terms, June 30, 1992– June 30, 1996): *Hilary T. O'Herlihy, M.D.; Cheryl E. Winchell, M.D.; Israel H. Weiner, M.D.; Augusto R. DeLeon, M.D.; Albert H. Dudley, Jr., M.D.; Sidney B. Seidman, M.D.*

The president thanked Dr. Lee-Llacer for his report.

President J. David Nagel, M.D. stated that the nominee for president-elect was Joseph Snyder and asked if there were any other nominations. Marvin Schneider, M.D. was nominated by Carol Bender, M.D. There were no other nominations, and the nominations for president-elect were closed.

Dr. Nagel stated that since Item 7 of the bylaws passed, it would not be necessary for the House of Delegates to elect a sixth member to the Committee on Scientific Activity. He also stated that the record should reflect that Dr. Myron I. Murdock was the nominee for the committee and the president-elect is hereby made aware of Dr. Murdock's eligibility for appointment to the committee.

Dr. Nagel stated that the nominee for the Finney Fund Committee was Susan R. Guarnieri, M.D. Since there were no other nominations, the nominations for the Finney Fund Committee were closed.

Dr. Nagel stated that the nominees for the two AMA delegate positions were Henry N. Wagner, M.D. and Roland T. Smoot, M.D. There were no further nominations for these two positions, and the nominations were closed.

Dr. Nagel stated that for the AMA (resident) alternate delegate position for the term beginning January 1, 1993 through December 31, 1995, the nominee was Eric Lon Shampaine, M.D. There were no other nominations and the nominations were closed.

Dr. Nagel stated that for the AMA (student) alternate delegate position, the nomination was Herman C. Maganzini, M.D. Robert Ferris was nominated by W. David Sullivan, president of the Student Component. Dr. Maganzini withdrew his name from the slate. The nominations were then closed. Since there was only one nominee, this was an uncontested office.

Dr. Nagel stated that the six nominees to fill the three vacancies on the Board of Physician Quality Assurance were Hilary T. O'Herlihy, M.D.; Cheryl E. Winchell, M.D.; Israel H. Weiner, M.D.; Augusto R. DeLeon, M.D.; Sidney B. Seidman, M.D.; and Albert H. Dudley, Jr., M.D.

Dr. Nagel mentioned that for these positions, advertisements were placed in the *Sun*, the *Evening Sun*, the *Washington Post*, and the *Maryland Medical Journal*, and solicitations were made to all component medical societies. Twenty-nine curricula vitae were received and reviewed by the Nominating Committee. The filing due date was March 16 and no further curricula vitae were to be considered after that date.

Dr. Nagel stated that nominations from the floor would be limited to those individuals who had filed before the deadline. A list of those names was provided to all delegates.

Allan Jensen, M.D., president of Baltimore City Medical Society,

nominated Mary M. Newman, M.D. as a nominee for the Board of Physician Quality Assurance. There were no other nominees, and the nominations were closed.

Dr. Nagel stated that if there were no objections in relation to all offices or positions that were not contested, ballot votes would be dispensed with for those positions. There were no objections. Dr. Nagel also mentioned that ballots would be prepared for all contested positions and that voting would take place as the first order of business during the second session of the House of Delegates on Saturday, May 2.

Council Actions

The president, J. David Nagel, M.D., stated that during the past year, the Council had filled vacancies in accordance with Article 4, Section 8. Those actions included

- For term ending at the close of the 1993 annual meeting for the office of secretary: *Carol W. Garvey, M.D.*
- For term ending at the close of the 1993 annual meeting for the office of treasurer: *Albert Blumberg, M.D.*

The following actions were taken by the Council: For the vacancy caused by the resignation of Dr. Antiltz as AMA Alternate Delegate: Louis Breschi, M.D. was appointed; for the vacancy caused by Dr. Nagel's resignation as AMA alternate delegate, Reynaldo L. Lee-Llacer, M.D. was appointed

Dr. Nagel inquired regarding the Council appointments. Dr. Harold

Bob moved that the House of Delegates reaffirm actions taken by the Council. A motion was made to amend the previous motion to extract the position of treasurer. Dr. Nagel stated that the position of treasurer was extracted and asked if there were any other comments. There being none, the House of Delegates voted to reaffirm all Council actions except that of the treasurer. Dr. Nagel opened the floor to nominations for the office of treasurer, and the names of Hiroshi Nakazawa, M.D. and Albert Blumberg, M.D. were submitted. There were no other nominees, and the nominations were closed.

Dr. Nagel informed the house that the position of treasurer, because it was contested, would be placed on the ballot for the election to be held during the second session of the House of Delegates on Saturday, May 2, 1992 at 2 p.m.

Rules for Nominating Speeches

Dr. Nagel announced the rules for nominating speeches so as to minimize confusion for the Saturday session. There will be two speakers per candidate, either the candidate himself/herself and/or a spokesperson for that candidate. Each speaker will be limited to three minutes. Since there was no objection to this procedure, Dr. Nagel stated that this would be the policy for the meeting.

Adjournment

There being no further business, the meeting was adjourned at 12:50 p.m.

Minutes of the House of Delegates—337th Meeting—Saturday, May 2, 1992

The 337th meeting of the House of Delegates of the Medical and Chirurgical Faculty was held on Saturday, May 2, 1992 in the Liberty Room of the Omni Hotel in Baltimore. Officers present were J. David Nagel, M.D., president; Jose M. Yosunico, M.D., president-elect; Carol W. Garvey, M.D., secretary; Albert L. Blumberg, M.D., treasurer; Marvin Schneider, M.D., first vice-president and chairperson of Council; Alex Azar, M.D., third vice-president; and Reynaldo L. Lee-Llacer, M.D., immediate past president.

The following delegates (or alternates) were registered as being in attendance; an asterisk next to a name denotes an alternate delegate. (Elective officers of the Faculty, AMA delegates, and past presidents are councilors.)

Allegany

Delegates

Victor R. Felipa, M.D.

Frederick Miltenberger, M.D.

Councilor

Leslie R. Miles, M.D.

Anne Arundel

Delegates

Sergio Alvarez-Velasco, M.D.

Leoncio A. Ceccarelli, M.D.²

Candace I. Chandler, M.D.

Jose M. Presbitero, M.D.¹

Jorge B. Ramirez, M.D.

Jorge M. Ramirez, M.D.¹

Councilor

Hilary T. O'Herlihy, M.D.

Baltimore City

Delegates

Joseph W. Berkow, M.D.

Paul Burgan, M.D.

Nijole B. Carozza, M.D.¹

Beverly A. Collins, M.D.

Augusto R. DeLeon, M.D.

K. George Dritsas, M.D.

Willarda V. Edwards, M.D.

Richard E. Fisher, M.D.¹

Albert Folgueras, M.D.

Frank A. Giargiana, Jr., M.D.

Rafael C. Haciski, M.D.

Thomas E. Hunt, M.D.

John Josselson, M.D.¹

Olusegun O. Lawoyin, M.D.

John B. MacGibbon, M.D.

Raymundo S. Magno, M.D.

Donald W. Mintzer, M.D.

Samuel I. O'Mansky, M.D.

Stephen K. Padussis, M.D.

Jerome Ross, M.D.¹

Bernard R. Shochet, M.D.

J. Andrew Summer, M.D.

George Taler, M.D.¹

Karl H. Weaver, M.D.

Joseph W. Zebley III, M.D.

Jack M. Zimmerman, M.D.

Councilors

James E. Bell, M.D.

Donald H. Dembo, M.D.

Susan R. Guarnieri, M.D.

Allan D. Jensen, M.D.

Hiroshi Nakazawa, M.D.

Gary L. Rosenberg, M.D.

Roland T. Smoot, M.D.³

Henry N. Wagner, M.D.³

Jose M. Yosunico, M.D.³

Baltimore County

Delegates

Ruben F. Ballesteros, M.D.

Marianne Benkert, M.D.

Robert K. Brookland, M.D.¹

John W. Buckley, M.D.

Maurice B. Furlong, M.D.¹

David A. Gussow, M.D.¹

Richard M. Hirata, M.D.

Deusdedit L. Jolbitado, M.D.

Frank T. Kasik, Jr., M.D.¹

Mayer C. Liebman, M.D.

Herbert J. Levickas, M.D.¹

Jose Martinez, M.D.¹

Elsa R. Merani, M.D.

N. Edward Nachlas, M.D.

Ronald J. Orrell, M.D.

Gary W. Pushkin, M.D.

Scott M. Rifkin, M.D.

Sidney B. Seidman, M.D.

Margaret L. Sherrard, M.D.

Kathleen E. Taylor, M.D.¹

Edward F. Wenzlaff, M.D.

H. Russell Wright, M.D.

Mehdi L. Yeganeh, M.D.¹

Councilors

Albert L. Blumberg, M.D.³

Louis C. Breschi, M.D.

Esther Edery, M.D.

Abdolhamid H. Ghiladi, M.D.

Christopher M. Harvey, M.D.

John H. Hebb, M.D.³

J. David Nagel, M.D.³

Calvert

Delegates

Michael J. Dodd, M.D.

Nancy I. Ulanovicz, M.D.¹

Councilor

Joseph S. Fastow, M.D.

Carroll

Delegate

Daniel I. Welliver, M.D.

Cecil

Delegate

Andrew P. Fridberg, M.D.²

Charles

Delegate

Kadar Baig, M.D.

Councilor

Guillermo E. Sanchez, M.D.

Dorchester

Delegates

Lewis M. Burdette, M.D.

Paul A. Stagg, M.D.²

Frederick

Councilor

Robert Thomas, M.D.

Garrett

Delegate

Herbert H. Leighton, M.D.

Harford

Delegate

Ben Oteyza, M.D.

Councilor

Frederick J. Hatem, M.D.

Howard

Delegates

Emidio Bianco, M.D.

Melvin S. Rapelyea, M.D.

Charles E. Taylor, M.D.

Brian J. Winter, M.D.

Councilor

Allan T. Leffler II, M.D.

¹ Alternate delegate

² Delegate serving both as councilor and delegate

³ Elected officer or AMA delegate

Minutes of the House of Delegates

Kent

Delegate

Harry P. Ross, M.D.

Montgomery

Delegates

Benjamin Avrunin, M.D.
Carol L. Bender, M.D.
*Christine D. Berg, M.D.*¹
Barbara L. Blaylock, M.D.
Larry M. Einbinder, M.D.
Ralph E. Longway, M.D.
Mark E. Mausner, M.D.
Edward S. Mehlman, M.D.
*Edwards J. Richards, M.D.*¹
Bruce E. Rubin, M.D.
Philip L. Schneider, M.D.
Mark S. Seigel, M.D.
Margaret T. Snow, M.D.
Eugene K. Sussman, M.D.
*Christopher Unger, M.D.*¹
Stephen G. Vaccarezza, M.D.
*Isaac Weiszer, M.D.*¹
Stephen W. White, M.D.

Councilors

*Carol W. Garvey, M.D.*³
Barton J. Gershen, M.D.
Herman C. Maganzini, M.D.
Francis C. Mayle, Jr., M.D.
*Marvin Schneider, M.D.*³
Donald S. Stepita, M.D.

Prince George's

Delegates

Brian S. Bayly, M.D.
James S. Chesley, M.D.
Said A. Dae, M.D.
Riad Dakheel, M.D.
Suresh C. Gupta, M.D.
Zorayda M. Lee-Llacer, M.D.
*Benjamin Maldonado, M.D.*¹
George S. Malouf, Jr., M.D.
David N. Robb, M.D.
Elie A. Sayan, M.D.
*Frederick Wilhelm, M.D.*¹

Councilors

Willie C. Blair, M.D.
Nelson G. Goodman, M.D.
*Reynaldo L. Lee-Llacer, M.D.*³
J. Richard Lilly, M.D.
*George S. Malouf, Sr., M.D.*³

Queen Anne's

Delegate

John R. Smith, M.D.

Talbot

Councilors

John A. Hawkinson, M.D.
Donald T. Lewers, M.D.

Washington

Delegates

Edward W. Ditto III, M.D.
Randy Sue Ellis, M.D.

Councilor

Francisco G. Japzon, M.D.

Wicomico

Delegates

*Hilda I. Houlihan, M.D.*²
Farouk A. Sultani, M.D.

Councilor

Alex Azar, M.D.

Worcester

Delegate

*Federico G. Arthes, M.D.*²

Resident

Delegates

*Cornelius Stamp, M.D.*¹

Student

Councilor

*Robert L. Ferris, M.D.*¹

Specialty Societies

Delegates

Jay Gerstenblith, M.D.
Richard B. Williams, M.D.

Councilor

Kenneth B. Lewis, M.D.

Board of Physician Quality Assurance

Delegate

Israel H. Weiner, M.D.

The following past presidents, some of whom are delegates, were also present: Raymond M. Atkins, M.D.; Michael R. Dobridge, M.D.; Reynaldo L. Lee-Llacer, M.D.; Donald T. Lewers, M.D.; George S. Malouf, Sr., M.D.; Francis C. Mayle, Jr., M.D.; and Roland T. Smoot, M.D.

Also present were the following executive directors: Neilson Andrews, Baltimore County; Diane Briggs, Prince George's County; Bernadette Lane, Baltimore City; and Edward Shanbacker, Montgomery County. The Faculty's executive director, Angelo J. Troisi, F.A.C.H.E., as well as other members of the Faculty's staff, was present.

Call to Order

The second session of the House of Delegates for the 1992 Med Chi Annual Meeting was called to order at 2:10 p.m. on Saturday, May 2, 1992 in the Liberty Room of the Omni Hotel in Baltimore by President J. David Nagel, M.D.

Visiting Dignitaries

President J. David Nagel, M.D. introduced the visiting dignitaries: Roselyn Epps, M.D., president, District of Columbia Medical Society; Constantino Amores, M.D., president, West Virginia Medical Society; John W. Hollowell, M.D., president, Virginia Medical Society; and Stephen R. Permut, M.D., president, Delaware Medical Society, and his wife Marlene.

Auxiliary Report

Mrs. Vivian Lynn, president of the Auxiliary, presented the Auxiliary's annual report.

Speeches for Nominees

President J. David Nagel, M.D. reminded the House of Delegates of the rules for speakers for those nominated to contested offices. There will be a maximum of two speakers for each candidate, each of whom shall speak no longer than three minutes.

For office of president-elect, the nominees were Joseph Snyder, M.D. and Marvin Schneider, M.D. Drs. Carol W. Garvey and Thomas E. Hunt spoke on behalf of Dr. Schneider. Drs. Reynaldo L. Lee-Llacer and Michael Dobridge spoke on behalf of Dr. Joseph Snyder.

For office of treasurer, the nominees were Albert Blumberg, M.D. and Hiroshi Nakazawa, M.D. Drs. Steve Padussis and Roland Smoot spoke on behalf of Dr. Nakazawa, and Drs. John Hebb and Donald Dembo spoke on behalf of Dr. Blumberg.

There are three vacancies for the Board of Physician Quality Assurance; six names must be submitted to the governor. The nominees were Augusto R. DeLeon, M.D.; Albert H. Dudley, Jr., M.D.; Mary M. Newman, M.D.; Hilary T. O'Herlihy, M.D.; Sidney Seidman, M.D.; Israel H. Weiner, M.D.; and Cheryl E. Winchell, M.D.

Dr. Joseph Fastow spoke on behalf of Dr. O'Herlihy; Dr. Paul Stagg spoke on behalf of Dr. Weiner; Dr. Allan

Jensen spoke on behalf of Dr. Newman; Dr. Blumberg spoke on behalf of Dr. Seidman; and Dr. Carol W. Garvey spoke on behalf of Dr. Winchell.

Tellers

J. David Nagel, M.D., the president, appointed the following tellers: Thomas Allen, M.D., Brian Bayly, M.D.; and Leslie R. Miles, Jr., M.D. The tellers handed out the ballots, collected them, and departed to count the ballots.

During the time the ballots were being counted, President J. David Nagel, M.D. continued with the House of Delegates agenda.

Board of Physician Quality Assurance Report

Israel Weiner, M.D., chairperson of the Board of Physician Quality Assurance (BPQA), presented the BPQA's report to the House of Delegates. Dr. Weiner discussed many of the legislative items that affect both the BPQA and Med Chi. One of the issues he mentioned was that now when a physician is charged, the charges will be made public. Previously charges were not released until final action had been taken.

There was some discussion about the fact that the BPQA's *final actions* were published in the *MMJ*, and it was questioned whether or not the *charges* would be published.

Dr. Weiner stated that the publication of the *final actions* in the *MMJ* had been Med Chi's decision and that he has always felt very uncomfortable with their publication. He stated that whether or not the *charges* to physicians would be published would be up to Med Chi.

Dr. Weiner discussed unconventional medical care. He also mentioned that the BPQA is getting ready to take action on a physician who uses unconventional medical practices and that there is "going to be a lot of out-cry" when this happens.

Other Business

President J. David Nagel, M.D. asked if there was any other business to come before the House of Delegates.

Carol Bender, M.D. and Ted Lewers, M.D. stated that they had issues they would like to bring before the house.

Dr. Bender discussed many of the issues that Montgomery County would like to see Med Chi take up during the upcoming year. Issues discussed included

- Concerns about the negative press physicians are receiving. Dr. Bender also stated that publishing BPQA charges to physicians in the *MMJ* was detrimental to the public image of physicians. She also mentioned that the *AMA News* does not always present the AMA views—it publishes negative press regarding physicians.
- Problems physicians are experiencing with the new laboratory and x-ray regulations
- AIDS testing for physicians is against their civil rights
- Self-referral position
- Practice guidelines
- Med Chi and AMA delegates should stand up for medicine.

Dr. Lewers stated that the Faculty must have unity; that there has been division, but now we are beginning a new future. He asked the group to work together on issues to bring "us" together.

Paul Stagg, M.D. stated that he would also like to discuss other business. He stated that, today, many of the nominees requested to speak at the Small Component Meeting. Because of time limitations, it was impossible. Dr. Stagg stated that they would welcome, in the future, having nominees talk to the group, and they would encourage them to do so, but they do need to know in advance because of time constraints.

Oath of Office

President J. David Nagel, M.D. asked President-elect Jose Yosunico, M.D. and his wife Dorothy to come forward. Dr. Nagel then swore in the new president and presented the President's Medallion to him.

Dr. Yosunico presented the Past President's Medallion to Dr. Nagel.

Both Dr. Yosunico and Dr. Nagel spoke to the House of Delegates.

Report of Tellers

The Teller Report was presented to the 1991-92 president, J. David Nagel, M.D., by the Chief Teller. Dr. Nagel announced the results as follows:

President-elect: *Joseph Snyder, M.D.*

Joseph Snyder, M.D.—90 votes
Marvin Schneider, M.D.—60 votes

Treasurer: *Albert Blumberg, M.D.*

Albert Blumberg, M.D.—77 votes
Hiroshi Nakazawa, M.D.—73 votes

Board of Physician Quality Assurance:
Augusto R. DeLeon, M.D.; Mary M. Newman, M.D.; Hilary T. O'Herlihy, M.D.; Sidney Seidman, M.D.; Israel H. Weiner, M.D.; and Cheryl E. Winchell, M.D.

Israel H. Weiner, M.D.—128 votes
Sidney B. Seidman, M.D.—111 votes
Augusto R. DeLeon, M.D.—99 votes
Cheryl E. Winchell, M.D.—97 votes
Hilary T. O'Herlihy, M.D.—92 votes
Mary M. Newman, M.D.—87 votes
Albert H. Dudley, Jr., M.D.—74 votes

(There were 151 voters. One ballot was disqualified.)

Drs. Snyder and Blumberg thanked members of the House of Delegates for their support.

Adjournment

There being no further business, the meeting was adjourned by President Jose Yosunico, M.D. at 3:35 p.m. Dr. Yosunico mentioned that a meeting of the Council would follow this meeting.

Committee on AIDS

Mr. President and Members of the House of Delegates:

In April 1991, the Maryland legislature passed House Bill 124, which required Med Chi, in consultation with the Centers for Disease Control (CDC), the Maryland Hospital Association (MHA), and the Department of Health and Mental Hygiene (DHMH), to develop a practice protocol for physicians infected with the human immunodeficiency virus (HIV).

From May to August 1991, the Committee on AIDS developed a protocol for physicians with HIV and presented it to two Med Chi reference committees for comments before it was introduced at the Med Chi House of Delegates meeting in September.

Senator Paula Hollinger and more than twenty physicians attended the first reference committee meeting held at Med Chi in August. During the meeting, members of the Committee on AIDS stressed that the committee spent a great deal of time on the protocol—time that could have been used to develop programs to improve access to care for HIV patients and to educate the public about the prevention of HIV transmission.

Members of the Committee on AIDS spoke with Senator Hollinger about Governor Schaefer's proposal to mandate HIV testing for patients and physicians in Maryland. Committee members emphasized the low risk of HIV transmission from physician to patient and the high cost of implementing an HIV-testing program. Senator Hollinger commented that the public is not aware of the low risk and high cost, and that efforts should be made to make the public aware of these facts. Members of the Committee on AIDS agreed that the media is more interested in sensationalist stories than in scientific data. It was agreed by physicians attending the reference committee meeting that Med Chi must attempt to educate the public and legislators about the low risk of HIV

transmission before the next legislative session.

To educate the public about the low risk of HIV transmission, Med Chi issued a news release in August that outlined Med Chi's opposition to any mandatory testing program of patients and physicians. The release received widespread coverage across the state and was featured in more than nine newspapers, on six radio stations, and on two television stations. The release emphasized that the lack of scientific data and the high costs of an HIV-testing program do not warrant a mandatory testing program.

To educate legislators about HIV transmission, the Committee on AIDS sent a series of three letters that outlined the following.

1. The low level of risk of HIV transmission.
2. The projected costs of a mandatory testing program.
3. Other arguments against mandatory testing.

These letters were also made available to Med Chi members through announcements in the "Executive Director's Newsletter." In response to the letters, Med Chi received numerous calls from legislators and twenty-four written replies.

In September 1991, Med Chi held a second reference committee meeting during the semiannual meeting in Ocean City. Over 150 physicians attended this session to voice their concerns about the protocol and mandatory testing of physicians for HIV.

After the second reference committee meeting, the House of Delegates modified and approved the protocol. At that time, the protocol, with regard to HIV, complied with the CDC "Recommendations for Preventing Transmission of Human Immunodeficiency Virus...to Patients During Exposure-Prone Invasive Procedures," as published in the *Morbidity and Mortality*

Weekly Report (MMWR) on July 12, 1991. The protocol included adherence to universal precautions and infection control practices and was intended to be applied to physicians only, although it may be applicable to other health care groups.

In the protocol, Med Chi requested the Maryland General Assembly to consider the following facts when developing any legislation relating to physicians infected with HIV.

1. Transmission of HIV from physician to patient has never been documented.
2. The CDC has calculated the risk of any possible future transmission as inconsequential in comparison to real risks of preventable death that the public accepts without question (e.g., smoking, failure to use seat belts, easy access to guns).
3. The transmission of HIV from patients to physicians has been documented.

The protocol stated that, despite these facts, the public is concerned with the negligible risk of transmission of HIV from physician to patient; the protocol was developed to address this concern.

According to the protocol, physicians infected with HIV who perform exposure-prone procedures would be evaluated to determine whether they should modify their professional activities to reduce the risk of HIV transmission to patients. The protocol further recommended that physicians who tested positive for HIV and who wished to continue performing exposure-prone procedures must seek counsel from an expert review panel or refrain from performing those procedures.

The panel would consist of a core group comprised of

1. A physician specialist in infectious disease, knowledgeable in HIV issues, who would be appointed by Med Chi and would be chairperson of the review panel.
2. A physician representing the state

- health department who would be appointed by the secretary of DHMH.
3. A physician representative who would be appointed by the Maryland Hospital Association.

Two other panel members would be selected by the core group and would be unique to each case. They are

4. The infected physician's personal physician or other physician designated by the infected physician.
5. A physician with expertise in the same specialty as the infected physician.

The protocol states that after the physician is evaluated by the panel, the infected physician would sign an advocacy contract stipulating what is expected of him or her. Physicians would be monitored quarterly, through a Health Services Cost Review Commission (HSCRC) database that creates an abstract for each hospital admission. In this database, physicians are assigned a unique identification number that can only be linked to the identity of the physician by Med Chi. This monitoring system would assure that the confidentiality of the infected physician was maintained.

Under the protocol, HIV-infected physicians, who knowingly performed exposure-prone procedures and did not voluntarily restrict themselves or seek advice from the panel, would be subject to action by the Board of Physician Quality Assurance (BPQA). HIV-infected physicians who violated the terms of their advocacy contract would also be subject to action by the BPQA. The protocol also included sections dealing with the liability of panel members and the confidentiality of HIV-infected physicians. The protocol did not recommend mandatory testing of physicians or health care workers.

During Med Chi's House of Delegates meeting, the section of the protocol on the advocacy contract and the section on physician compliance were extracted to be reviewed by the Faculty's legal counsel. These sections were approved by the Council in November 1991.

In December 1991, committee

member Katherine Harrison, M.D. presented the protocol to the Maryland House Ways and Means Committee and expertly fielded questions from legislators about the protocol.

Committee members traveled to Annapolis several times during the 1992 legislative session to testify on more than twenty bills related to AIDS and HIV. Committee Vice-Chairperson John Bartlett, M.D., along with Drs. Katherine Harrison, Gregory Rausch, Randy Berger, and Andrew Fridberg generously donated their time to testify and used the opportunity to educate legislators about the realities surrounding HIV and AIDS.

Med Chi testified in favor of the four HIV-related bills that passed this session. They were

HB 388: Human Immunodeficiency Virus Protection Act

This bill mandated all hospitals and other health agencies around the state to require their employees to follow the CDC's universal precautions. It also requires all health care providers to comply with the CDC's universal precautions.

HB 505/SB 332: Criminal Offenders—HIV Testing—Victim Notification

Under this bill, individuals charged with certain offenses involving the transfer of bodily fluids must furnish a blood sample and submit to an HIV test. It allows disclosure of test results to victims.

HB 460/SB 277: Reporting of HIV Infection and Low CD4+ Count

This bill added HIV and a low CD4+ count to the list of reportable diseases. Laboratories that report these results may not report the identity of the patient, but must use a unique identification number.

HB 257: AIDS Insurance Assistance Pilot Program

This bill extended the Maryland AIDS Insurance Assistance Pilot Program beyond its two-year pilot period

for two more years. The program helps those who have HIV and who have lost their jobs to obtain health insurance.

Committee members also testified in opposition to a number of bills that did not pass. The bills included those designed to mandate HIV testing of health care workers and patients such as

SB 3: Health Care Facilities—HIV Testing—Surgical Patients

This bill would have required all surgical patients to be tested for HIV before surgery could be performed.

SB 7: Health Care Providers— HIV Positive Status—Performing Exposure-Prone Procedures— Penalty

This bill would have prohibited an HIV-infected health care worker from intentionally performing an exposure-prone procedure unless notification was given to the patient.

SB 18: Health Care Providers— Performing Exposure-Prone Procedures—HIV Testing

This bill would have required health care workers to be tested for HIV at their own expense every six months. The bill would also have required HIV-positive physicians to report to an expert review panel before performing exposure-prone procedures.

HB 644: HIV Testing—Patients and Health Care Workers— Exposure-Prone Invasive Procedures and Exposures

This bill would have required health care workers who perform exposure-prone procedures to be periodically tested for HIV. HIV-positive health care workers would have been required to comply with the recommendations of an expert panel. Non-compliant workers would have been reported to their licensing board. The bill also would have required patients undergoing exposure-prone invasive procedures to be tested for HIV and to

notify health care workers of the test result.

After the legislative session, the committee sponsored a session on "Caring for the HIV-Positive Patient" during the 1992 Med Chi Annual Meeting. During the session, Carla Alexander, M.D. spoke on "Counseling the HIV-Positive Patient"; David A. Wheeler, M.D. spoke on "Laboratory and Clinical Evaluations"; John Bartlett, M.D. spoke on "Opportunistic Infections in the HIV-Positive Patient"; and Judith Feinberg, M.D. spoke on "Retroviral and Other AIDS Therapies."

The Committee on AIDS has had a very active year. As chairperson, I thank all the members of the committee who have generously donated so much time and effort to this committee this year. I also would like to give a special thanks to all those who served as consultants for the *Practice Protocol for Physicians with HIV*.

Fred A. Gill, M.D., chairperson

John G. Bartlett, M.D., vice-chairperson

Carla S. Alexander, M.D.

Robert J. Ancona, M.D.

Randy S. Berger, M.D.

Stanley L. Blum, M.D.

John C. Downs, M.D.

Andrew P. Fridberg, M.D.

John M. Henderson, M.D.

P.G. Rausch, M.D.

Janet L. Rice, M.D.

Margaret T. Snow, M.D.

Phuong D. Trinh, M.D.

John R. Warfield, M.D.

David A. Wheeler, M.D.

Daniel C. Wilkerson, M.D.

Advisory members

Kathleen Edwards, Ph.D., R.N.

Eric Fine, M.D.

Joyce Harper, M.D.

Katherine Harrison, M.D.

Carmine M. Valente, Ph.D.

Consultants for the Practice Protocol for Physicians with HIV

Mike Compton

Joseph Horman, M.D.

Audrey Rogers

Steven J. Sumner

J. Andrew Sumner, M.D.

Jack Zimmerman, M.D.

Committee on Alcoholism and Chemical Dependency

Mr. President and Members of the House of Delegates:

The Committee on Alcoholism and Chemical Dependency continued its efforts toward raising awareness of the dangers of alcohol and drug abuse, including smoking. Ten meetings were held during the past year.

The committee supported legislation to increase taxes on the sale of alcohol and tobacco products in Maryland with the hope of decreasing and discouraging their consumption, especially among our youth. It is also hoped that health care costs will be lowered due to fewer tobacco-related illnesses. The committee also supported bills restricting the sale of tobacco products by vending machines and measures restricting smoking at the new Oriole Park at Camden Yards. Unfortunately, these bills were defeated in the state legislature.

In addition, the committee supported the recognition of Jarrettsville Elementary School for its role in bringing about the first nonsmoking policy on school premises in Maryland. The committee continues to support the adoption of nonsmoking policies in all Maryland schools.

The committee sponsored the presentation "How To Help Your Patients Stop Smoking" at Med Chi's 1991 Semiannual Meeting.

Also supported by the committee was the inclusion of tobacco use data in all state reports on substance use and abuse. The committee instigated a letter to the governor from Med Chi's president, J. David Nagel, M.D., on this topic. In a letter dated May 21, 1992, the governor responded by stating that tobacco use data will be included henceforth.

In cooperation with the Physician Rehabilitation Committee, the committee sponsored a highly successful

conference, "Addiction: Prevention, Recognition, and Treatment," which took place on November 16, 1991.

The committee also cosponsored two presentations at Med Chi's 194th Annual Meeting: "Assessment and Care of the Alcohol-Using Patient" and "Substance Abuse: Physician Attitudes, Beliefs, and Practices." Both presentations were well received.

The committee also expressed concerns over state addiction treatment fund cuts and the effect these cuts will have on individuals in need of treatment.

The committee continues to work diligently to address a wide range of substance abuse concerns, including supporting the concept that physicians should not display magazines with tobacco advertising in their waiting rooms.

The committee looks forward to cosponsoring another drug conference, the "Third Annual Conference on Addiction: Physician Health and Education," in the fall of 1992.

I wish to thank the Faculty, the committee members, and Med Chi staff for their assistance and support this past year.

Franklin T. Evans, M.D., chairperson

Jonathan D. Book, M.D.

Claude R. Feinstein, M.D.

John H. Hirschfeld, M.D.

Abraham M. Schneidmuhl, M.D.

Beatrice L. Selvin, M.D.

Advisory members

Isadore Kaplan, M.D.

Patricia Lancelotta, R.N.

Ludwig L. Lankford

Phil McKenna

W. Robert Miller

Philip P. Nolan, D.D.S.

Computers in Medicine Committee

Mr. President and Members of the House of Delegates:

The Computers in Medicine Committee maintains the Maryland Med-Sig—the computerized bulletin board system of the Medical and Chirurgial Faculty. Dr. H. Gerald Oster has been the system operator (SYSOP) of Med-Sig since its inception.

The committee continues to give computer demonstrations to hospital medical staffs using a computer with a modem, a phone line, and a projection system. Under the direction of Dr. Rafael C. Haciski, the committee's chairperson, a three-hour seminar dealing with office computerization on the industry's leading equipment was given at the Faculty's 1992 Annual Meeting. Included were demonstrations of office management software, medical

software, and some of the new experimental programs being used on the Apple computer and IBM-compatible systems.

The committee sponsored a three-part seminar in March on "Computers in the Medical Office." The program dealt with office computerization and hardware requirements, and also offered a hands-on demonstration of computer equipment by the participating vendors.

The committee demonstrated the Med-Sig bulletin board system at the Faculty's 1991 Semiannual Meeting in Ocean City last September and is planning a similar demonstration for the Faculty's 1992 Semiannual Meeting.

Rafael C. Haciski, M.D., chairperson

Charles P. Adamo, M.D.

Norman K. Bohrer, M.D.

Martin Berger, M.D.

Dino E. Flores, M.D.

Uwe G. Goehlert, M.D.

Charles A. Hartjen, M.D.

Guillermo S. Linsao, M.D.

Albert Nahum, M.D.

Avigdor I. Niv, M.D.

H. Gerald Oster, M.D.

William D. Parnes, M.D.

Michael P. Parsons, M.D.

William J. Pogoda, M.D.

Stephen J. Rockower, M.D.

Jeffrey C. Schultz, M.D.

Mark S. Seigel, M.D.

Chao-son Teng, M.D.

Continuing Medical Education Review Committee

Mr. President and Members of the House of Delegates:

The Continuing Medical Education Review Committee (CMERC) met five times during this past year, carrying out its responsibilities in monitoring the sixty-two hospitals and other organizations now accredited by Med Chi to sponsor intrastate continuing medical education activities. These CME activities are eligible for Category 1 of the AMA's Physician Recognition Award. Associated with the authority to accredit institutions to sponsor CME activities is the obligation to provide education, guidance, consultation, and assistance to the institutions as they strive to provide the best possible educational activities for their physicians. The committee

- visited thirteen sponsors (site visits);
- met with representatives of two sponsors at Med Chi (reverse site visits);
- granted new accreditation to two sponsors;
- cited three sponsors for noncompliance with the *Essentials and Guidelines for Accreditation of Sponsors of*

CME, placing one on probation for one year;

- reviewed forty-five interim reports; and
- re-accredited twelve sponsors.

Nationally, there has been a greatly increased emphasis on all the regulations concerning the sponsorship of CME activities this year, including a high level of interest shown by the Food and Drug Administration. That agency is particularly concerned about the commercial support of CME activities.

As part of their program to disseminate information to accredited groups, the CMERC sponsored a workshop on "Accreditation for Continuing Medical Education" at Med Chi's 1992 Annual Meeting, which was attended by over seventy physicians and CME staff personnel from throughout the state.

The following hospitals and organizations are accredited by Med Chi:

1. American Cancer Society—Maryland Division

2. American Heart Association—Maryland Affiliate
3. American Lung Association of Maryland
4. Anne Arundel Medical Center
5. Baltimore County General Hospital
6. Bon Secours Hospital
7. Carroll County General Hospital
8. Chestnut Lodge Hospital
9. The Children's Hospital and Center for Reconstructive Surgery, Inc.
10. Church Hospital
11. Community Psychiatric Clinic, Inc.
12. Crownsville Hospital Center
13. Doctors Community Hospital
14. Dorchester General Hospital
15. Fallston General Hospital
16. Franklin Square Hospital Center
17. Frederick Memorial Hospital
18. Good Samaritan Hospital
19. Greater Baltimore Medical Center
20. Greater Laurel—Beltsville Hospital
21. Harbor Hospital Center
22. Harford Memorial Hospital
23. Holy Cross Hospital
24. Howard County General Hospital, Inc.
25. J. Lawrence Kernan Hospital, Inc.
26. Leland Memorial Hospital
27. Liberty Medical Center, Inc.

Committee on Drugs

Mr. President and Members of the House of Delegates:

The bylaws of the Medical and Surgical Faculty state that the Committee on Drugs shall be "responsible for evaluating the appropriateness of prescribing controlled dangerous drugs and shall work closely with appropriate governmental authorities in controlling the abuse of controlled dangerous substances by physicians."

The Committee on Drugs carries out this charge by evaluating the prescribing practices of physicians referred to the committee by the Board of Physician Quality Assurance (BPQA). These referrals are the result of consumer complaints or, in some instances, routine pharmacy surveys that identify questionable prescriptions of controlled substances. Evaluations are carried out through reviews of pharmacy surveys and patient charts by appropriate specialists, discussions of specialist findings by the whole committee, and, where deemed appropriate by the committee, interviews with the physicians concerned.

In addition to its participation in the BPQA peer review process, the committee carried out its charge in other ways. Chairperson Stephen Hirsch, M.D. served on the Governor's Commission on Drug Abuse as the representative selected by the Faculty's president and participated in the formulation of recommendations by the commission's Education Subcommittee. The recommendations—still in draft form—include provisions to ensure that health care professionals receive appropriate education in the area of substance abuse.

The committee also has a specific statutorily mandated role in the process by which physicians receive approval for the use of amphetamines and methamphetamines. State regulations state that physicians must receive prior approval from the Division of Drug Control's medical consultant to

prescribe methamphetamines. Physicians wishing to prescribe amphetamines must notify the medical consultant within ten days of the initial prescription and supply the medical consultant with a diagnosis. If there is any doubt as to the validity of the diagnosis of a condition justifying the use of amphetamines, the medical consultant shall submit the documentation to Med Chi's Committee on Drugs for that committee's review and advice. (In 1991, as in past years, the secretary of the Department of Health and Mental Hygiene appointed the chairperson of the Committee on Drugs as medical consultant.)

The Committee on Drugs reminds all physicians in Maryland of their responsibility to request approval for the use of amphetamines from the medical consultant. Requests should be addressed to the chairperson of the Committee on Drugs at the Faculty offices.

The committee continues to strive to maintain a balance between educating physicians about their prescribing practices and supporting discipline for those who abuse these privileges.

The chairperson appreciates the continued dedication and commitment of committee members and Med Chi staff to the education of physicians in this important aspect of their practice.

Stephen A. Hirsch, M.D., chairperson

Harbhajan S. Ajrawat, M.D.

George H.A. Bone, M.D.

Maxie T. Collier, M.D.

Thomas C. Cullis, M.D.

Lewis H. Dennis, M.D.

Stanley Z. Felsenberg, M.D.

Nelson H. Hendler, M.D.

Ramesh K. Khurana, M.D.

Lawrence Y. Kline, M.D.

Cresenciano C. Lopez, M.D.

Patrick J. Sheehan, M.D.

John A. Singer, M.D.

John R. Smith, M.D.

Richard F. Tyson, M.D.

28. Maryland General Hospital
29. Maryland Hospital Education Institute
30. The Maryland Psychiatric Society, Inc.
31. Maryland Radiological Society
32. Maryland State Black Psychiatrists' Association
33. The Memorial Hospital and Medical Center of Cumberland, Inc.
34. Memorial Hospital of Easton, MD
35. Mercy Medical Center
36. Montgomery County Medical Society
37. Montgomery County Department of Addiction, Victim and Mental Health Services
38. Montgomery General Hospital
39. Monumental City Medical Society
40. Office of Health Services/National Security Agency
41. The Neurology Center, P.A.
42. North Arundel Hospital
43. Peninsula General Hospital
44. Psychiatric Institute of Montgomery County and Fairbridge Residential Treatment Center
45. Prince George's County Medical Society
46. Prince George's Hospital Center
47. Sacred Heart Hospital
48. St. Agnes Hospital
49. St. Joseph Hospital
50. Shady Grove Adventist Hospital
51. Sheppard and Enoch Pratt Hospital
52. Sinai Hospital
53. Southern Maryland Hospital, Inc.
54. Spring Grove Hospital
55. Springfield Hospital Center
56. Suburban Hospital
57. Taylor Manor Hospital
58. Union Memorial Hospital
59. University of Maryland Health Center
60. Veterans' Administration Medical Center
61. Washington Adventist Hospital
62. Washington County Hospital

William L. Thomas, M.D., chairperson

James Castellano, M.D.

Irvin H. Cohen, M.D.

Worth B. Daniels, Jr., M.D.

Orlando R. Davis, M.D.

Maen Jamal Farha, M.D.

J. Blaine Fitzgerald, M.D.

Jawad U. Hasnain, M.D.

Carol J. Johns, M.D.

Deusdedit Jolbitado, M.D.

Henry H. Kwah, M.D.

Abdul Nayeem, M.D.

R. Kennedy Skipton, M.D.

Carl A. Soderstrom, M.D.

Bernard Tabatznik, M.D.

Advisory member

Jack L. Mason, Ph.D.

Emergency Medical Services Committee

Mr. President and Members of the House of Delegates:

The Emergency Medical Services (EMS) Committee conducted three meetings during the report period. A number of issues, including legislative bills that have a direct impact on emergency medicine, were discussed and actions taken. Because of the magnitude and significance of some issues, discussions and actions must be continued over the next years.

Funding of EMS, MIEMSS

The governor's 1993 budget was implemented by the University of Maryland through a 63 percent budget cut to the EMS system—essentially MIEMSS (Maryland Institute for Emergency Medical Services Systems). At all three meetings, the committee considered strategies for managing the disastrous impact of cuts on EMS services, training, and equipment as it would affect the citizens and physicians in the state. (The current state EMS programs were developed, with significant help by Med Chi, over a twenty-year period of time, and have served as model programs for many states and international communities.) Letters were prepared for the Faculty president's signature and dispatched to the president of the Maryland Senate, the House majority whip, and the chancellor of the University of Maryland. The result was the restoration of the EMS (MIEMSS) budget to the same \$6.8 million level of the previous year, \$4.3 million of which will come from funds specifically raised for this purpose.

Emergency department overcrowding

Emergency department (ED) overcrowding is an ongoing concern. A survey conducted by the Maryland Chapter, American College of Emergency Physicians (ACEP) showed that 75 percent of hospital emergency de-

partments in Maryland experience conditions in which there are regularly too many patients for the department design and staffing level. Emergency health care is affected. The problem is one that cannot be fixed easily since many factors come to bear. The basic problem appears to be an insufficient number of hospital beds during specific times, thus patients cannot be admitted from the ED. This lack of beds leads to a back-up, a decreased level of care, and longer waiting times for patients. Increasing EMS use by the elderly; "dumping" of nursing home patients; homeless issues; changing practice patterns by private physicians; societal problems involving drugs, alcohol, and violence; and the increasing prevalence of AIDS (acquired immunodeficiency syndrome), all lead to increased utilization of emergency services and emergency department overcrowding. These issues will continue to be addressed at committee meetings, probably for several years.

Survey of component medical societies

To determine the impact of the governor's EMS budget cut throughout the state, the committee surveyed all the component medical societies. A response rate of nearly 70 percent was received. Nearly all societies reported that funding cuts would affect staffing, equipment purchases and maintenance, patient transport, communications, and certification and training.

Legislative issues

The EMS Committee was successful in getting the Conjoint Managed Care Task Force recommendations for an HMO (health maintenance organization) agreement finalized and approved by the Med Chi Council and Executive Committee.

Legislation to improve communications between HMOs and emergency physicians was introduced by Med Chi and ACEP and passed in the 1991 legislative assembly. New problems were experienced in the latter half of 1991 that prompted the introduction of multiple bills by Med Chi/ACEP in order to further improve communications with HMOs. Several of these bills passed, while others failed and will require the committee's continuing efforts during the coming year.

Other issues reviewed and discussed included

- MIEMSS Director Search Committee
- Ameen Ramzy, M.D. replacement at MIEMSS
- HCFA (Health Care Financing Administration) charge/resolutions at Shady Grove Hospital
- Access to emergency care by the homeless and elderly
- Motorcycle helmet legislation
- EMS protocols
- Interface with Maryland and National ACEP
- DNR (Do Not Resuscitate) orders proposed for legislation
- Emergency medicine article for *MMJ*

It has been my pleasure to serve Med Chi as the chairperson of the Emergency Medical Services Committee.

Peter M. Fahrney, M.D., chairperson
Barbara J. Bach, M.D.
Lawrence F. Blob, M.D.
Alexander P. Cadoux, M.D.
Randy Sue Ellis, M.D.
Jeffrey L. Fillmore, M.D.
Sergio B. Mateo, M.D.
Ameen I. Ramzy, M.D.
Walter L. Scheetz, M.D.
Michael A. Stang, M.D.
Harold Sussman, M.D.

Finance Committee

Mr. President and Members of the House of Delegates:

In 1991, the Finance Committee was increased to seven members, including the treasurer, making it more efficient in carrying out its charge.

After carefully considering investment results and thoroughly investigating various options, Rittenhouse Financial Services, Inc. was appointed to manage the assets of the Faculty's investment portfolio and retirement plan. Smith Barney was chosen as custodian of the investment assets.

Now that the Physician Rehabilitation Program is being funded by monies collected from physicians through state licensing fees, the committee recommended that the purpose of the \$10 annual dues assessment be revised. The House of Delegates approved the use of the funds for other member services.

Guidelines were established for expenditures in connection with the annual and semiannual meetings and the AMA Delegation activities. These guidelines, which were approved by the Council in September, will assist in more accurate forecasting for budget development.

The committee met several times with staff to develop the 1992 budget, which was adopted by the Council in November 1991. The bylaws have been amended so that the annual budget will be approved at the last Council meeting of the prior year, rather than the first meeting of the budget year.

Sheldon B. Bearman, M.D., chairperson
Albert M. Antlitz, M.D.
Albert L. Blumberg, M.D.
Joel L. Falik, M.D.
Allan D. Jensen, M.D.
Francis C. Mayle, Jr., M.D.
J. David Nagel, M.D.

Focused Professional Education Committee

Mr. President and Members of the House of Delegates:

In its first full year at Med Chi, the Focused Professional Education Committee has designed and implemented a process through which it offers individualized remedial education. The committee offers evaluation and focused medical education to physicians with defined deficits in their practices. The committee seeks thereby to provide for those physicians a resource to improve their care of patients.

Since May 1991, the committee has received referrals from peer review organizations, hospitals, licensing boards, and individual physicians. Referrals have also come from surrounding states, including New Jersey, Rhode Island, and West Virginia. Each evaluation that has taken place has resulted in an extensive report, focusing on the deficits in a physician's practice, assessing the physician's needs, and addressing those needs through specific educational recommendations.

In addition to its case work, the committee has written a handbook to define its process and policies. The handbook serves two purposes. First, it guides physicians who volunteer to work in the program as evaluators, pre-

ceptors, and course coordinators. Second, the handbook provides a source of information for interested organizations involved in peer review and quality care—organizations outside of Med Chi and outside of Maryland.

Throughout its first year, the committee has maintained close contact with the University of Maryland School of Medicine as a resource for evaluators and courses. A priority for the committee in the coming year is to establish specifically focused courses at the University of Maryland School of Medicine to fill commonly encountered needs, for example, in the area of medical records.

Those involved with the program hope that it will continue to grow in its ability to serve physicians in Maryland and that it will continue to provide a resource for physicians outside the state.

Edward J. Kowalewski, M.D., chairperson
Pablo E. Dibos, M.D.
Ronald J. Cohen, M.D.
E. George Elias, M.D.
Kevin S. Ferentz, M.D.
Michael J. Richardson, M.D.
Sidney B. Seidman, M.D.
Elliece S. Smith, M.D.

Immunizations and Infectious Diseases Subcommittee

Mr. President and Members of the House of Delegates:

During the 1991-1992 year, the Immunizations and Infectious Diseases Subcommittee reviewed the changes to Code of Maryland Regulations (COMAR) 10.06.04 (Required Immunizations before Entry into a Maryland School) as recommended by the Department of Health and Mental Hygiene (DHMH). The subcommittee approved the changes and made some recommendations, which were incorporated into the regulations. Some of the changes in the regulations involved requiring children who enter kindergarten and sixth grade in September 1992 to have proof of having received two doses of measles vaccine and one

dose of mumps vaccine, or a blood test showing immunity to both diseases. A phase-in schedule for two doses of the measles vaccine would appear in the regulations, and the immunizations' schedule would appear in the regulations. The Faculty approved the subcommittee's recommendations.

As part of the governor's campaign for a measles-free Maryland, the subcommittee recommended printing a letter in the *Maryland Medical Journal (MMJ)* from Secretary Sabatini concerning the governor's campaign. This recommendation was approved by the Faculty and the letter appeared in the October 1991 issue of the *MMJ*. The

Committee Reports

Faculty's representative to the governor's campaign for a measles-free Maryland was Robert J. Ancona, M.D., chairperson of the subcommittee.

The subcommittee also reviewed changes to COMAR 10.06.01 (Communicable Diseases) and made suggestions for the word "outbreak" to be defined as an "outbreak as determined by the secretary," and also suggested that reference to COMAR 10.06.01.12 (Measles) be incorporated in the changed regulations. Further recommendations included a clearer wording of COMAR 10.06.01D (Measles, Proof of Immunity, Hospital Workers).

After reviewing the vaccine information booklets published by the US Department of Health and Human Services, the subcommittee presented information about the booklets for inclusion in the "Executive Director's Newsletter," *MMJ*, March 1992.

With concern mounting about the spread of hepatitis B, the subcommittee reviewed current data and recommended that the Faculty support offering hepatitis B vaccine to infants. The Faculty approved of this recommendation, which was published in the June edition of the *MMJ*, along with suggested immunization schedules.

Another pressing concern was the new OSHA (Occupational Safety and Health Administration) regulations for occupational exposure to bloodborne pathogens. After thorough review of the regulations and discussions with MOSH (Maryland Occupational Safety and Health) representatives, the subcommittee made the following recommendations, which were approved by the Faculty.

1. That the Faculty circulate information concerning the OSHA regulations to

all Med Chi members and the specialty societies.

2. That the Faculty provide every physician member (free of charge) with information on the OSHA regulations to include the standard; an exposure-control plan; and information about recordkeeping, hepatitis B vaccinations, training, housekeeping, protective equipment, and labels and signs.

After final review by the chairperson of the subcommittee, the Model Exposure Control Plan was printed and distributed to Med Chi physicians.

Robert J. Ancona, M.D., chairperson

Timothy F. Doran, M.D.

Clayton L. Moravec, M.D.

Mathuram Santosham, M.D.

Robert E. Yim, M.D.

Associate members

Diane Dwyer, M.D.

Margaret Rennels, M.D.

Ad Hoc Special Committee on Laboratory Regulations

Mr. President and Members of the House of Delegates:

During the 1991-1992 year, the Ad Hoc Special Committee on Laboratory Regulations worked diligently to present the concerns and issues of office-based physicians to the Maryland Laboratory Advisory Committee (LAC). Joint meetings between the Faculty's ad hoc committee and LAC resulted in revisions of the laboratory regulations and the use of an educational approach by the state laboratory inspectors.

Issues addressed by the ad hoc committee during the last year were

1. Decreased fees for small office practices
2. Office testing specific to a physician's specialty
3. Laboratory director serving as laboratory supervisor when only certain tests were performed in the office
4. Clarification and revision of record-keeping regulations
5. Centrifuge calibration requirements
6. Throat cultures as exempt tests
7. Treatment of "excepted" tests during inspections of licensed laboratories
8. Use of the term "linearity"
9. Regulatory impact on rural practitioners
10. Revision of the regulations relating to

cholesterol testing and separating out the issue of mass screening

11. Proficiency testing requirements and quality controls
12. Standard operating procedure manuals (SOPM)

Many of the changes recommended by the ad hoc committee were approved by LAC and forwarded as proposed regulations.

The joint effort between LAC and the ad hoc committee also resulted in a session, at the Faculty's 1991 Annual Meeting, on laboratory regulations and the performance of testing in physician office laboratories. A Med Chi booth was also manned by state laboratory administration personnel who were available to answer physician inquiries and concerns. Helpful handouts were also provided at the booth.

In February, the Clinical Laboratory Improvement Amendments of 1988 (CLIA 88) were published in the *Federal Register*. These regulations preempt the state's regulations. Under the federal regulations, some differences between the state and federal programs are increased regulatory fees, required unannounced inspec-

tions, and limited waivers to the following eight tests (dipstick or tablet reagent urinalysis for bilirubin, glucose, hemoglobin, ketone, leukocytes, nitrite, pH, protein, urobilinogen, and specific gravity; ovulation tests—visual color tests for human luteinizing hormone; urine pregnancy tests—visual color comparison determination; erythrocyte sedimentation rate—non-automated; hemoglobin by copper sulfate; fecal occult blood; spun hematocrit; and blood glucose—Food and Drug Administration (FDA)—cleared home use devices). In the months ahead, the ad hoc committee will be addressing the CLIA regulations and the state's efforts to obtain exempt status under CLIA 88 and to retain control of laboratory testing.

Carol W. Garvey, M.D., M.P.H., chairperson

Stuart B. Bell, M.D.

Esther Edery, M.D.

Eugene P. Libre, M.D.

Frank A. Pedreira, M.D.

Michael A. Samri, M.D., M.P.H.

Leon G. Sheer, M.D.

Stanley M. Silverberg, M.D.

Ronald C. Sroka, M.D.

Legislative Committee

Mr. President and Members of the House of Delegates

During 1991-1992, the Legislative Committee worked on behalf of Med Chi members, as well as all Maryland physicians, to ensure representation in the General Assembly on medical-related issues. The committee supported the passage of key public health legislation and opposed legislation that would be detrimental to the citizens of Maryland and the profession of medicine.

Public health issues

AIDS. Several AIDS (acquired immunodeficiency syndrome) bills were considered during the legislative session. Med Chi supported and arranged for physicians to testify on many of these bills.

The first successful bill mandated that, upon written request of the victim, an individual charged with a criminal offense or delinquent acts involving a possible exposure must submit to an AIDS test (SB332/HB505).

Second, HB460 requires laboratories to report HIV-positive (human immunodeficiency virus) results and CD4+ counts if less than 200/mm³. However, the bill provides for the confidentiality of the patient by mandating the use of a unique identifier—to be developed and implemented by the Department of Health and Mental Hygiene (DHMH) by October 1, 1993—requiring only that the patient's age, sex, race, and zip code be reported. Physicians and hospitals will also be required to use a unique identifier.

HB388 requires hospitals, related institutions, freestanding medical facilities and birthing centers, and certain HMOs (health maintenance organizations) to adopt policies, for all employees and medical staff, that are in compliance with CDC (Centers for Disease Control) guidelines and universal precautions. The facilities must post a written notice of the CDC guidelines and precautions or face a possible

\$500 fine. According to this bill, all health care workers who have hands-on patient contact must comply with the CDC guidelines, and the Board of Physician Quality Assurance (BPQA) may make unannounced inspections to insure compliance if a signed complaint is made.

Also passed was HB257 (Ch. 44), which continues the Maryland AIDS Insurance Assistance Pilot Program that helps HIV-afflicted persons who have lost their jobs purchase health insurance.

Eight bills aimed at mandating HIV testing of health care workers and patients were defeated in the General Assembly:

- HB 644 would have required periodic HIV testing of health care workers who perform exposure-prone procedures.
- SB18 would have required all health care workers who perform exposure-prone procedures to be tested every six months at their own expense.
- SB7 would have required HIV-positive health care workers to inform patients of their HIV status prior to performing a medical or dental exposure-prone procedure.
- HB163 would have required patients to disclose their HIV and hepatitis B virus (HBV) status upon admission to a health care facility, and, in turn, health care providers who engaged in exposure-prone procedures would have been required to disclose their HIV and HBV status to patients prior to rendering services.
- SB3 would have required patients to submit a blood sample for HIV testing prior to entering a health care facility for an invasive surgical procedure.
- SB278/HB459 called for HIV testing of a patient, at the request of an exposed emergency worker but with the consent of the patient, when exposure had occurred be-

tween the patient and emergency personnel (firefighter, emergency medical technician, rescue squad member, law enforcement officer).

- HB402, a bill similar to SB278/HB459, would have required testing of patients when exposure had occurred between patient and emergency personnel, but would have allowed emergency personnel to have the patient tested without the patient's consent.
- HB47 would have required inmates to be tested for HIV upon entering and exiting a correctional institution.

Two other AIDS-related bills also failed to pass:

- SB2/HB1206 would have required a mortician to be notified if a deceased person had had AIDS, an AIDS-related disease, or an HIV infection, or this information would have had to appear on the death certificate.
- HB17 would have required that the names of persons testing positive for HIV be reported to DHMH.

Smoking. Med Chi strongly supported a meaningful tax increase on cigarettes out of a concern for the public and participated in the governor's press conference on this issue. Although the governor insisted on a 25 cents per pack raise, the 1992 Special Session increased the tobacco tax by only 20 cents per pack, with the increase in revenues designated to the General Fund. However, prior to testimony by medical experts, the Ways and Means Committee had refused to recommend any excise tax increase for tobacco products. Unfortunately, SB372, which would have required smoking and nonsmoking areas in all indoor areas except bars and restaurants, was defeated in the Environmental Matters Committee for the third year in a row. A law that would have given smokers protection from

workplace discrimination not even afforded to women, minorities, and the disabled (SB 704) received only one senator's vote in judicial proceedings.

Alcohol and drugs. Parents or guardians can now admit a minor, involuntarily, to alcohol or drug treatment facilities (SB580/HB1334), although the facility must note that the admission was made without the minor's consent. However, an effort to stop fetal alcohol syndrome, HB561, which would have required the posting of a birth defects warning sign by those holding retail class alcoholic beverage licenses, failed.

Silicon breast implants. According to HB1508, a physician is prohibited from performing silicon breast implants except in accordance with the Food and Drug Administration's rules and regulations or recommendations for usage of silicone gel breast implants.

Other issues. Two public health initiatives that saw defeat last year, saw success this session. SB43 makes it illegal to leave a loaded firearm in a place where a minor could gain access to it. Also, efforts by physicians and other health care professionals were rewarded with the reinstatement of the motorcycle helmet law (HB377/SB4).

Regulation of health professions

Physicians. Three important bills having an impact on the regulation of physicians were passed this session. SB654 continues the BPQA to July 1, 2003 and makes some changes to the BPQA's regulatory and disciplinary authority:

1. The BPQA can contract for the purchase of mediation services to resolve fee disputes
2. The BPQA can enact disciplinary action for overutilization of health care services in place of overcharging
3. The BPQA is authorized to impose fines and issue advisory opinions.

HB313 mandates all foreign medical school graduates to complete a uniform three-year training period or accredited postgraduate medical train-

ing program and repeals the current law that exempted foreign medical school graduates from this requirement, provided their medical school was approved by the BPQA.

SB695 allows the BPQA to license a foreign physician by virtue of his or her conceded eminence and authority in the profession. The physician must be recommended by the dean of a school of medicine in the state or by the director of the National Institutes of Health.

Other health care providers. Last year, legislation attempted to require all physicians to employ radiation technologists to perform even the simplest x-rays. This session, HB1339—sponsored by Rose Mary Bonsack and supported by Med Chi—was passed, allowing a physician to designate specified x-ray duties to an individual who performs other functions most of the time and who has taken a course (approved by the Maryland Radiological Society in consultation with the Maryland Society of Radiologic Technologists) consisting of at least thirty hours of training in performing x-ray procedures and has successfully passed an approved examination.

Despite the best efforts of the medical and orthopaedic communities, SB405 has altered the scope of practice for podiatrists and authorizes a podiatrist to diagnose or surgically, medically, or mechanically treat any ailment of the human ankle or any ailment of the anatomical structures that attach to the human foot. However, a podiatrist is specifically prohibited from performing triple arthrodesis, ankle fusions, or surgical treatment of ankle trauma. All surgical procedures of the ankle below the level of the dermis, arthrodeses of two or more tarsal bones, and complete tarsal osteotomies are required to be performed in a hospital.

HB1087 establishes a new certified social worker—clinical license that authorizes a holder of the license to apply social work principles and methods to alleviate social, mental, and emotional conditions through treat-

ment designed to provide psychotherapy for a mental disorder and to render a diagnosis based on a recognized manual of mental and emotional disorders. The bill also eliminates the requirement that a person be referred to a social worker by a physician to qualify for insurance reimbursement.

Health care practitioner investment. Despite Med Chi's testimony and the March 4th Legislative Rally, Delegate Gun's self-referral bill (HB1374) failed because an agreement could not be reached on final amendments in the last days of the session. Amended to account for some of Med Chi's concerns, this bill would have prohibited a health care practitioner from referring patients to health care services in which the practitioner or the practitioner's family owned a beneficial interest or had a compensation agreement.

Membership of health occupation boards. HB56 established a uniform four-year term of membership for each member of a health occupation board and prohibits a member from serving more than two consecutive full terms. HB5 directs the governor to fill any vacancy on a health occupation board within sixty days of the vacancy. The governor is also given the authority to remove a member who, as reported by the secretary of the Department of Health and Mental Hygiene, misses more than two meetings without good cause. Consumer members are limited to proctoring or monitoring examinations of the boards.

Public service requirements. Med Chi supported, and legislators passed, HB1002, which authorizes a professional licensing occupational board to take disciplinary action against a licensee who fails to comply with a public service requirement that was a condition of the individual's receipt of a state or federal loan or scholarship for dental, nursing, medical, or physician's assistant education.

Major medical equipment. HB1242 allows for the continuation of the licensure program for major medical equipment, but changed the scope

of the program to include specific types of equipment instead of equipment costing \$600,000 or more. Equipment that will be subject to licensure regardless of cost includes computed tomography (CT) scanners, magnetic resonance imagers (MRIs), linear accelerators, cardiac catheterization equipment, lithotripters, and radiation therapy equipment.

Regulatory agencies. Two regulatory agency bills passed. The first (SB197) continues the Health Services Cost Review Commission until July 1, 2003. The second (SB198) continues the Health Resources Planning Commission until July 1, 2003, reinstates the requirement that health maintenance organizations be subject to the certificate of need law, and prohibits a kidney treatment facility from becoming a facility to provide kidney transplant services without obtaining a certificate of need.

Health care financing and cost containment

Insurance issues. Med Chi was instrumental in proposing measures leading to SB591/HB987, which made significant changes in the requirements for utilization review:

1. A hospital no longer needs to have an objective second opinion component in its utilization review program.
2. A private review agent must submit, to the secretary of Health and Human Services, a utilization review plan that includes the specific criteria and standards the agent will use in conducting utilization review of proposed or delivered health care services.
3. All adverse decisions related to the proposed or delivered health care services must be made by a physician or a panel of other appropriate health care providers with at least one physician panel member.
4. If an adverse decision is appealed by a patient or health care provider, the final decision of the appeal must be made in writing with specific explanations and the criteria and standards used to make the decision.
5. Decisions on authorization or certification of a non-emergency course of treatment for a patient must be made

within two working days after all needed information is received.

6. Decisions on authorization or certification of an extended stay in a health care facility or additional health care services must be made within one working day. The attending health care provider must have the opportunity to seek a reconsideration of that decision within twenty-four hours.
7. An adverse decision may not be rendered by the private review agent for emergency inpatient admissions solely because the hospital did not notify the agent within twenty-four hours, as long as the patient's medical condition prevented the hospital from determining the patient's insurance status and the private review agents emergency admission notification requirements.

Heavily supported by the medical community, SB562/HB1378 requires health care practitioners and hospitals to use a single uniform claims form, which will be adopted by the insurance commissioner, for submitting a claim or bill to third-party payers. This form must be accepted by third-party payers as the only vehicle for claims reimbursement, but third-party payers can request additional medical information if necessary.

Insurers are now required to provide annual benefit summaries of inpatient and outpatient services (SB176/HB960). These reports must include (1) the amount the insurer reimbursed each provider, and (2) the amount owed by the consumer for each service.

Fraudulent insurance acts were defined (HB1380) for agents, brokers, insurers, and other persons. Fraudulent acts for an insurer include writing or placing business with an unlicensed agent, operating without a certificate of authority, and making a false sworn statement.

HB621 would have required bills for health care services to include itemized charges for procedures provided to the consumer. If a service was listed but not rendered, the billing party would have to reimburse the consumer and credit the bill.

SB734/HB1417 would have created an independent fraud bureau in the insurance division to investigate insurance fraud.

Three bills addressed the issue of mandated benefits. SB371/HB1044 extended the reimbursement level for outpatient mental health visits through June 30, 1995. However, another mental illness bill failed, SB70/HB558. This bill would have required health insurers and HMOs to cover serious mental illnesses on the same terms as physical illness.

SB269/HB485 mandates the inclusion of child wellness services in family insurance policies, but allows copayments and deductibles to be imposed for the new services. The policy must include

- immunizations
- PKU (phenylketonuria) tests
- screening tests for tuberculosis
- anemia screening
- lead toxicity screening
- hearing and vision tests
- parental anticipatory guidance

An effort at small group market reform, HB374 would have guaranteed that small businesses (two to twenty-five employees) have access to insurance coverage. It would have forced insurers to write policies for small businesses and also would have forced insurers to stay within certain rate bands.

HMO issues. Two issues relating to payment of claims by HMOs failed. SB459/HB1143 would have codified a standard definition of emergency services to clarify under what circumstances an HMO must reimburse providers of emergency services to HMO subscribers.

SB504/HB800 would have required HMOs to reimburse noncontracting health care providers at the rate billed or at the provider's usual, customary, and reasonable (UCR) rate. The bills were intended to prevent HMOs from arbitrarily reducing payments to non-plan physicians.

Oversight committees. The Joint Committee on Health Care Cost Containment was abolished by SB610/HB1148, which created a new Joint Committee on Health Care Delivery and Financing to provide over-

Committee Reports

sight and study on issues relating to health care delivery or financing.

Also drafted to establish a special joint committee, HB376 would have developed a plan to provide health care coverage for all Maryland residents by December 1992, but the bill failed.

Albert L. Blumberg, M.D., chairperson

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Anne Arundel County Medical Society

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William W. Mullins, Jr., M.D.

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Wicomico County Medical Society

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Richard H. Meeks, M.D.

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Robert L. Lyles, M.D.

Henry L. Sherwood, M.D.

Maryland Society of Cardiology

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Stephen R. Kay, M.D.

Maryland Psychiatric Society, Inc.

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Bruce A. Hersheyfield, M.D.

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Maryland Chapter, American College of Surgeons

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Charles Leve, M.D.

Maryland Thoracic Society

Steven A. Schonfeld, M.D.

Maryland Urological Society

Robert B. Goldstein, M.D.

Auxiliary

Dan DeVito

Carol Allen

Sue Sherwood

Library and History Committee

Mr. President and Members of the House of Delegates:

During 1991-92, the Library and History Committee met four times. The committee spent much time reviewing the library's needs and, as a result, established a historian/administrator position within the library. We also continued work on Med Chi's bicentennial celebration and addressed issues of collections care and management.

1. **Historian/administrator.** The committee, with the support of the president and the executive director, coordinated the selection of a candidate to fill the position of historical administrator. Ms. Margaret N. Burri, formerly curator at the Maryland Historical Society, assumed this position on March 24, 1992.

2. **Bicentennial.** At its April 8th meeting, the committee recommended that the incoming president, Jose M. Yosuco, M.D., appoint members to a Bicentennial Committee devoted to the affairs surrounding the Faculty's 200th anniversary. The committee proposed that the Bicentennial Committee be chaired by Ronald H. Fishbein, M.D., chairperson of the Library and History Committee, with additional members drawn from other pertinent committees. It was also recommended that the committee include nonvoting advisory members from the medical history community.

The committee identified three projects for the bicentennial: a one-volume history of medicine in Maryland; a joint exhibit with the Maryland Science Center; and care and conservation of the historic collections.

3. **Issues of collection care and management.** The committee developed an outgoing loan agreement and set three collections management goals for the remainder of 1992: inventory and relabeling of the portrait collection; creation of an illustrated booklet to ac-

company the portrait collection; and inventory of the medical instruments. These projects will help library staff and the committee identify outstanding conservation concerns.

The committee continued to work with library staff to reevaluate the number of journal subscriptions. As a result, subscription costs were reduced by over \$2,000. Finally, members of the Volunteer Physician Cataloging

Project helped staff process and catalog items in the rare book collection.

Ronald H. Fishbein, M.D., chairperson
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Victor E. Albites, M.D.
Edward Cornfeld, M.D.
Milford M. Foxwell, M.D.
Stanford M. Goldman, M.D.
Nancy T. Nichols, M.D.
Henry B. Wilson, M.D.
Theodore E. Woodward, M.D.

Committee on Long-Term Care and Geriatrics

Mr. President and Members of the House of Delegates:

Continuing its longstanding commitment to assuring the highest quality of care in long-term care facilities, the Committee on Long-Term Care and Geriatrics concentrated on establishing medical quality assurance guidelines in long-term care institutions. By means of a spring 1992 survey to nursing home medical directors, alternates, and members of the academic community, the committee hopes to establish a statewide consensus on the minimum standards of care in nursing home medicine, thereby enhancing the quality of medical care delivered in nursing homes. The survey addressed standardization of documentation of mandated physician/patient interactions; clarification of medical staff responsibilities for purpose of quality assurance and for license and certification surveys; and the documentation necessary for a re-evaluation or for reimbursement for services.

The committee, in cooperation with the American Medical Association, sponsored a scientific session at the

1992 Med Chi Annual Meeting. The session, "Medical Management in Home Care," was designated as the Jesse C. Coggins, M.D. Memorial Lecture; attendance and response were excellent.

The committee looks forward to the coming year and will strive to provide appropriate education to physicians and the public. The chairperson appreciates the dedication of the committee members and the Med Chi staff.

George Taler, M.D., chairperson
John F. Hartman, M.D.
Herbert J. Levickas, M.D.
Allan H. Macht, M.D.
Elsa R. Merani, M.D.
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Ruben Reider, M.D.
Paul S. Rhodes, M.D.
Aubrey D. Richardson, M.D.
Joseph Shear, M.D.
Gordon M. Smith, M.D.
John R. Smith, M.D.
Joseph W. Zebley, M.D.

Advisory members
Lois Leonard, M.D.
Steven Levinson, M.D.

Committee on Managed Care and Third-Party Liaison

Mr. President and Members of the House of Delegates:

During the 1991-1992 year, the Committee on Managed Care and Third-Party Liaison addressed a number of important issues.

The committee reviewed and commented on a number of Medicare policies. Specialty society input was solicited on several of these policies. Some of the policies commented on by the committee were myocardial perfusion studies; nerve conduction studies; repetitive stimulation and pneumatic compressor devices; injections into soft tissues and tendons; durable medical equipment (DME) policies; and limitation of one office visit per month when a physical therapy program is in effect.

Because health maintenance organization (HMO) issues appeared on every committee agenda, the committee invited HMO representation in order to address global issues that continue to resurface in relation to HMO care. While information concerning the issues was provided by various HMOs, several issues are still outstanding and will be addressed by the committee at future meetings.

One of the legislative issues addressed by the committee concerned formulating recommendations regarding HMO legislation. These recommendations were forwarded to the Faculty's lobbyist for inclusion in HMO legislation.

Other legislative issues reviewed and discussed by the committee concerned workers' compensation legislation and universal access to health care. Comments by the committee were forwarded to the Faculty's lobbyist.

The implementation of Medicare's new fee schedule and the revision of the CPT (current procedural terminology) codes prompted active participation by the committee's chairperson in meetings with the Health Care Financing Administration (HCFA) and Faculty representatives. The chairperson,

on behalf of the committee, provided valuable input with regard to the Faculty's response on the proposed fee schedule, comments related to the new CPT codes, and the "hassle factor" experienced by practicing physicians. Dialogue with HCFA officials provided the opportunity to place the concerns and questions of the physicians squarely before Medicare policymakers.

Problems related to Maryland Blue Cross/Blue Shield's (BC/BS) computer system were discussed and reviewed by the committee and forwarded to staff to address the issues with the carrier.

A new policy issued by Maryland BC/BS concerning the placement of the date of onset on all claims prompted letters and complaints to the committee. The vice-president and corporate medical director of the carrier was invited to address this issue at one of the committee's meetings in which representatives from the Medical Group Management Association (MGMA) and the Faculty's president were present. The input of committee members and MGMA and the concerns expressed by other organizations and Med Chi members prompted the Faculty's Executive Committee to address the date of onset issue directly with Carl J. Sardegna, chairperson and chief executive officer, Maryland BC/BS. This action resulted in a change in policy with the carrier requiring only the date of onset on specific claims.

Another Maryland BC/BS policy raised numerous concerns, inquiries, and comments from physicians and office staff. Specifically, the carrier sent a notice that effective May 1, 1992, physicians could be charged if they requested a duplicate payment voucher or check status or if it was necessary to pull claims history information in order to respond to an in-

quiry. Payment had to be made before information would be forthcoming from the carrier. Reimbursement problems with the carrier prompted physicians to strongly oppose this new policy. The committee brought this issue to the attention of the Faculty's Executive Committee, which addressed the issue immediately with the carrier. Because of the concern expressed by the Faculty about this policy, the vice-president/corporate medical director responded to physician members at Med Chi's 1992 Annual Meeting and clarified the new policy. He acknowledged that only in those few instances in which the carrier has identified a practice that has repeatedly lost or misplaced its vouchers and other claims information would the physician be charged for inquiries.

Physician concerns about release of physicians' ghost number by the Faculty were discussed by the committee. The committee recommended to Council that the Faculty not support or endorse Barton-Gillet Physician Services. This issue was referred to the Executive Committee for further investigation and action. Issues related to Barton-Gillet were referred to the Executive Committee as they surfaced.

Because of repeated questions about Maryland BC/BS's claims review process and appeal process, the committee asked the vice-president/corporate medical director to provide current information that could be published in one of Med Chi's publications. This information was provided by the carrier and was published in the "Executive Director's Newsletter," *Maryland Medical Journal*.

Issues surrounding the new HCFA 1500 form were discussed by the committee, and concerns were forwarded to HCFA, various carriers, and Maryland Medicaid. Because there were

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numerous changes with regard to the form, the carrier was invited to hold training sessions at the Faculty building. These training sessions were attended by office staff and physicians.

The committee also discussed and provided information on various inquiries concerning mammography reimbursement, reimbursement for rare procedures in children, unilateral vs bilateral procedures, silicone implants, eye muscle surgery, outpatient

tonsillectomies and adenoidectomies, psychiatric reimbursement, interest on claims not paid within thirty days, and UCR (usual, customary, and reasonable) issues.

Donald H. Denbo, M.D., chairperson

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Selvin Passen, M.D.

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David M. Solomon, M.D.

Kempamma Sudhakar, M.D.

Stephan L. Werner, M.D.

Advisory members

Barry S. Gold, M.D.

Arthur T. Keefe, Jr., M.D.

Maryland Medical Journal Editorial Board

Mr. President and Members of the House of Delegates:

This report covers the calendar year 1991 (Volume 40). Throughout this period, the Editorial Board of the *Maryland Medical Journal* encouraged the submission of original research, case studies, review articles, medical history, and diagnostic and therapeutic updates, as well as commentaries and letters to the editor on all subjects of interest to Maryland physicians.

Following tradition, the January issue included Med Chi's Legislative Directory; the May issue featured Med Chi's 1991-1992 president, J. David Nagel, M.D.; and the August issue consisted of annual reports.

Three Maryland hospitals were highlighted during the year: the University of Maryland School of Medicine's 184 years of history was the theme in March; research conducted by Harbor Hospital Center house staff was included in the April and May issues; and the 125th anniversary of Sinai Hospital of Baltimore was the focus of the June issue.

Henry N. Wagner, Jr., M.D., winner of the AMA's Scientific Achievement Award, and Donald E. Wilson, M.D., dean of the University of Maryland School of Medicine, were profiled in July and December, respectively.

The Maryland Lupus Foundation coordinated the much acclaimed issue

on systemic lupus erythematosus, which was published in October.

Two new departments were established in 1991: "Word Rounds" by Bart Gershen, M.D. and "Clinical Observations." In addition, editorials began to appear on a more regular basis.

There were twelve board meetings during the period. A total of 156 manuscripts were reviewed, an 8 percent increase over 1990. Of the manuscripts reviewed, 104 were ultimately accepted for publication, 30 were not approved, 16 were returned to authors with recommendations for revisions, 5 were referred to the *Physician's Practice Digest*, and 1 is currently being evaluated by a guest reviewer.

Barry S. Gold, M.D. and Robert A. Barish, M.D. were selected for the fifth annual Best *MMJ* Article Award for their fascinating and comprehensive treatise, "Venomous Snakebites," which appeared in the September 1990 issue.

The editorial board is most grateful to those specialists who graciously contributed their time and expertise in reviewing manuscripts. The following physicians assisted in *MMJ*'s review process during 1991: Thomas E. Allen, M.D.; Mark M. Applefield, M.D.; John G. Bartlett, M.D.; William R. Bell, M.D.; Peter O. Kwiterovich, M.D.; H. Lorin Lau, M.D., M.P.H.; Martha Jane Matjasko, M.D.; Travis

Meredith, M.D.; and Charles A. Schiffer, M.D.

Total page count for Volume 40 was 1,150 (up fourteen pages from the previous year). Distribution averaged 7,769 per month, up from 7,735 in 1990. Advertising space averaged 32 percent, down slightly from the previous year. Postage, paper, and production costs continued to rise, but income kept pace.

As always, those associated with the production of the *Maryland Medical Journal* appreciate the careful attention of individual department editors who monitor their columns for scientific accuracy and correct citations.

The Editorial Board of the *Maryland Medical Journal* encourages Med Chi members to communicate regularly and often about any and all facets of the publication.

Victor R. Hrehorovich, M.D., editor

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Sc.D., associate editor

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DeWitt E. DeLawter, M.D.

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Fred J. Heldrich, M.D.

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Advisory member

Carmine M. Valente, Ph.D.

Maternal Welfare Subcommittee

Mr. President and Members of the House of Delegates:

During the 1991-1992 year, the Maternal Welfare Subcommittee addressed the issue of the Supreme Court's ruling in *Rust v Sullivan*, which determined that federally funded family planning clinics cannot discuss abortion with pregnant women or provide information about where to obtain an abortion. The subcommittee presented a policy statement supporting free discussion between physicians and patients to the Public Health Committee, which presented the recommendation to the Faculty's Council; the Council adopted it as a policy statement.

Another issue of concern was abortion guidelines for abortion clinics. In 1973, the Faculty promulgated abortion clinic guidelines, which were approved by the Council. These guidelines were formulated in response to concerns that abortion clinics were not regulated by the state. In the past, the Faculty had some inspection responsibilities in relation to abortion clinics; however, the Faculty had long since abandoned any inspection-type activities. Therefore, the Faculty's Executive Committee asked the subcommittee to review the abortion

clinic guidelines to determine if they were still appropriate. After review, discussion, revision, and updating of the abortion clinic guidelines, the subcommittee determined that the new guidelines should be made available as helpful information to those outpatient facilities that were delivering abortion services and to state legislators and state agencies that were inquiring about the guidelines. However, in view of the ongoing controversy surrounding abortions and the cases currently before the Supreme Court, the Faculty chose to file the guidelines at the present time.

Further efforts by the subcommittee focused on maternal mortalities. With the Faculty's approval, the subcommittee pursued the issue of conducting maternal mortality reviews for educational purposes. After securing an agreement with the Department of Health and Mental Hygiene (DHMH) on obtaining maternal mortality data, the subcommittee will start implementing maternal mortality reviews this coming year. Cooperation with hospital department chairpersons will play an integral part in this project.

The subcommittee's efforts in the area of perinatal/infant mortalities will be coordinated with the Baltimore City Health Department's Healthy Start Program. (The Healthy Start Program is a community-based attack on infant mortality with the goal of reducing infant mortality by 50 percent over five years.) The Faculty approved of the subcommittee's joint endeavors with regard to conducting a perinatal/infant mortality review in targeted areas of the city.

Review of the correspondence from the Maryland Medical Assistance Program on generic substitution of oral contraceptives led the subcommittee to recommend, and the Faculty to approve, this policy for generic substitution.

Harrold T. Elberfeld, M.D., chairperson
Joyce M. Boyd, M.D.

Rudiger Breiteneker, M.D.

Harold D. Gabel, M.D.

Carol W. Garvey, M.D.

Phillip J. Goldstein, M.D.

John A. Hawkinson, M.D.

Timothy R.B. Johnson, M.D.

Russell Moy, M.D.

J. Courtland Robinson, M.D.

Liaison Committee with the Medical Assistance Program

Mr. President and Members of the House of Delegates:

During the 1991-1992 year, the Liaison Committee with the Medical Assistance Program brought two important issues to the attention of the Executive Committee and the Council. The first issue related to the Provider Fee Project. This project imposed a tax on certain Medical Assistance, Maryland Pharmacy Assistance, and Prenatal Assistance Program provider groups. The purpose of the program was "to generate additional state general funds through enhanced federal

financial participation in reimbursements for services rendered" by the above-mentioned provider groups (Maryland Medical Assistance Program Provider Fee Project Transmittal No. 1). The tax did not change the way providers billed or the amount of *net* reimbursement providers received. Physicians, concerned about what impact this tax would have on their practice, contacted the Faculty and expressed their concerns about Internal Revenue Service (IRS) audits; re-

porting of actual income rather than income reported on the state's voucher but not received from the state; misrepresentation of allowable charges; the legality of the tax; and ethical issues related to perceived deceptive practices. As a result of these concerns, Nelson Sabatini, secretary, Department of Health and Mental Hygiene (DHMH), addressed the Faculty's Executive Committee and Council on this issue, and made himself and the DHMH available to com-

Committee Reports

ponent medical societies and specialty societies in order to allay concerns and misunderstandings about the project. The Faculty and DHMH worked together to address physician concerns about clarity of the Medical Assistance voucher and the 1099 business form. DHMH also supplied the Faculty with information from the Attorney General's Office, which verified the legality of the provider fee tax. At the current time, DHMH has informed the Faculty that the issue of federal reimbursement to the state is being litigated.

The second important issue brought to the attention of the Executive Committee and Council concerned the issue of billing the Maryland Medical Assistance Program for cross-coverage. Medical Assistance had informed physicians that the program's regulations did not permit physicians to bill for services performed by physicians who covered for them. After the Faculty alerted the Medical Assistance Program to the pertinent federal law, which allowed billing for services of a

substitute physician under Medicaid, the Maryland Medical Assistance Program removed the edit in the program's computerized payment system that prevented payment to physicians who billed for cross-coverage.

Further efforts involved promotion of the Maryland Access to Care (MAC) program. Efforts in this area continue.

The concept of a portable medical record for use by Medical Assistance patients was supported by the committee and presented to the Council. Council approved of this concept, which provides a record for medical data that is portable, can be generated by the Medical Assistance Program, and is combined with the recertification process.

Various medication issues involving the coverage of certain medications were discussed and input was solicited from the Faculty's Ad Hoc Therapeutic and Formulary Committee. DHMH was provided with input from both committees concerning this issue.

Referral of correspondence to the committee concerning the coverage for

bilateral tubal ligations (BTLs) performed in outpatient settings prompted the Medical Assistance Program to propose a code for outpatient tubal ligations and to add BTLs to the procedures that are allowable in ambulatory surgical centers for Medicaid recipients.

The committee also disseminated information contained in the article, "Medical Malpractice Claims Filed by Medicaid and Non-Medicaid Recipients in Maryland." This article appeared in the June 12, 1991 issue of the *Journal of the American Medical Association*, (Vol. 265, No. 22); the lead author was Mary Mussman, M.D., physician advisor, Office of the Secretary, Department of Health and Mental Hygiene.

Gary L. Rosenberg, M.D., chairperson

Irvin B. Kaplan, M.D.

Selvin Passen, M.D.

Reed A. Winston, M.D.

Joseph W. Zebley III, M.D.

Advisory members

Lawrence R. Payne

Mary Mussman, M.D., M.P.H.

Nelson J. Sabatini

Ad Hoc Committee on Medical Radiation and Nuclear Technologist Regulations

Mr. President and Members of the House of Delegates:

During the 1991-1992 year, the Ad Hoc Committee on Medical Radiation and Nuclear Technologists Regulations addressed two very important issues that had an impact on the delivery of medical care in Maryland. These issues were (1) the establishment of mammography standards and (2) the ability of personnel in physicians' offices to continue to perform limited radiography.

In order to properly address these issues, the Faculty's ad hoc committee took the lead in assembling interested parties from the following departments and organizations: Board of Physician Quality Assurance (BPQA), Department of Health and Mental Hygiene (DHMH); Office of Licensing and Certification Programs (OLCP), DHMH; Radiologic Health Programs (RHP),

Department of the Environment (DE); Maryland Radiological Society (MRS); Maryland Hospital Association (MHA); and the Maryland Society of Radiologic Technologists, Inc. (MSRT). Representatives from these various entities met with members of the Faculty's ad hoc committee to discuss issues and concerns in relation to the mammography standards and the radiation technologist regulations.

Furthermore, the ad hoc committee organized and coordinated the presentation on the mammography standards and the radiation technologist regulations for the Faculty's 1991 Semiannual Meeting in Ocean City, where the issues were reviewed, discussed, and debated.

All of the above-mentioned entities were in agreement that the mammog-

raphy standards promulgated by the American College of Radiology and the Health Care Financing Administration were appropriate standards for mammography testing and did not require the development of separate or more stringent standards.

With regard to the issue of who is qualified to take x-rays in physicians' offices, the following positions were taken:

1. The BPQA's subcommittee believed that there should be limited licensure (skull, spine, chest, extremities, podiatric x-rays) for individuals taking x-rays in physicians' offices; these individuals would have to complete a course of study approved by the Joint Review Committee on Education in Radiology Technology or any equivalent program in limited radiographic procedures with the burden of equiva-

lency falling on the applicant or, as an alternative to the education requirement, submit documentation of work experience of one to two years as a limited scope radiographer; these individuals would have to pass the national examination provided by the American Registry of Radiologic Technologists or an equivalent examination with a grade of 75, after adjustment for error; these individuals could practice only in facilities with a single x-ray unit per address under the supervision of a licensed physician or practitioner authorized to practice radiology; and these individuals would have to complete thirty hours of relevant continuing education per renewal period (probably every two years).

2. The Maryland Hospital Association supported the concept of limited practice for individuals taking x-rays if appropriate and formal training was provided. MHA originally viewed these individuals as being employed in a range of locations that included hospitals, clinic, and health maintenance organizations (HMOs). They also viewed the practice of limited radiography as an entry-level position for radiologic technology and suggested consideration be given to career and educational mobility.
3. The Department of the Environment, Radiologic Health Programs, supported the concepts of limited practice, accountability, and formal training.
4. The MSRT was not in favor of limited licensure.
5. The Maryland Board of Nursing took the position that the Maryland Nurse Practice Act does not prohibit such activity by properly trained nurses (R.N. or L.P.N.) if appropriately delegated by a licensed physician.
6. The Maryland Radiological Society supported the concept of limited licensure if there were additional limits on the practice: (1) practice only in facilities with single unit machines; (2) direct supervision by a licensed physician or licensed practitioner; (3) the physician or practitioner must be on the premises during the taking of all x-rays; and (4) the physician or practitioner must certify that the individual has received proper training.
7. Med Chi supported the taking of x-rays in physicians' offices provided that there be limits on the type of x-rays that could be taken, the office personnel were under the direct supervision

of the physician, and training would be assured.

Med Chi contracted with DACUM (Developing a Curriculum) Resource Center at Dundalk Community College to work with a facilitator in order to take the initial steps toward defining skills, attributes, and training that would be required for individuals taking x-rays in physicians' offices. As a result of this effort, a DACUM profile was compiled for individuals taking x-rays in physicians' offices and presented to the BPQA, MRS, MSRT, MHA, the Maryland legislature, and other interested parties.

However, after several joint meetings, correspondence, and numerous conversations to try to reach an agreement about office x-rays, and after testifying before the BPQA (12/3/91), it was obvious that differences of opinion still existed between various groups.

In testimony before the Maryland legislature in December 1991, the Faculty's ad hoc committee testified in support of the availability of x-rays performed by trained office personnel in physicians' offices.

Realizing that the availability of x-ray services in physicians' offices was threatened, the Faculty then directed its lobbyist to draft legislation, H.B. 1339, which assured that individuals could perform x-rays in physicians' offices if the x-rays were of a limited

nature; the individual was not employed primarily to take x-rays; the physician delegated the duties; the individual took a course and passed a test based on that course; and the individual participated in continuing education.

In the meantime, the ad hoc committee pursued the next step in the DACUM process, which was to design a course curriculum for individuals who took x-rays in physicians' offices. With input from ad hoc committee members, radiologists, MRS, radiation technologists, individuals presently taking office x-rays, and physicians who take x-rays in their offices, a course curriculum was formulated. This course was presented to the governor's office for informational purposes.

H.B. 1339 was signed into law on May 26, 1992, thus ensuring that accessibility to office x-rays will continue.

Michael A. Sauri, M.D., chairperson

Albert L. Blumberg, M.D.

Robert D. Brodell, M.D.

John C. Gordon, M.D.

Harry C. Knipp, M.D.

Daniel C. McCabe, M.D.

Edward S. Mehlman, M.D.

Francis D. Milligan, M.D.

Juan M. Pardo, M.D.

Henry Roth, M.D.

Ronald C. Sroka, M.D.

Stanley M. Silverberg, M.D.

Robert B. Stoltz, M.D.

Committee on Medicine and the Performing Arts

Mr. President and Members of the House of Delegates:

The year 1991-92 saw the Committee on Medicine and the Performing Arts busier than ever, fulfilling a charge expanded the previous year. Several advisory members were added to the committee, representing allied health and music fields. The committee met nine times.

On January 24-25, 1992, the committee was pleased to hold the first conference in this region on "Performing Arts Medicine: Issues in Diagnosis and Management" at the Faculty build-

ing. Australian physician Hunter Fry, M.S., a specialist in overuse injuries experienced by musicians, was the keynote speaker. Other professionals in medicine, allied health, music, and library science gave presentations on epidemiology of performance-related problems, medicolegal issues, upper extremity disorders, stress management, ergonomics, and special problems of professional dancers.

More than seventy physicians, allied health professionals, musicians,

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and students attended the two-day conference. Responses were positive. A reporter from the American Medical News Group was present and articles appeared in *Family Practice News* and *Internal Medicine News*. The committee is planning a similar meeting next year when Dr. Fry will return to continue his research at the National Institutes of Health (NIH).

The *Maryland Medical Journal* has accepted the committee's proposal for a dedicated issue in early 1993 based on presentations given at the January conference.

The committee also sponsored a session at the Med Chi Annual Meeting on May 1, 1992. Dr. James McDonald, a Lutherville, MD audiologist, spoke on "Hearing Issues for the 1990s."

News of the Music Medicine Clearinghouse, an extensive cumulative bibliography of articles on medical problems of musicians, continued to spread, mostly by word of mouth, at related conferences. Clearinghouse bibliographies were given out at the Medical Problems of Musicians and Dancers Symposium in Aspen, CO; the International Conference of Symphony and Opera Musicians Annual Meeting in Vail, CO; the Playing Less Hurt Conference in Tampa, FL; and the International Cello Festival in England. Information about the Clearinghouse also appeared on the Music Library Association's electronic mail service.

The committee plans to further publicize the clearinghouse and its related activities and to make a substantial impact on health care for performing artists of the mid-Atlantic region.

John B. DeHoff, M.D., chairperson

Emidio Bianco, M.D.

Harold B. Bob, M.D.

Scott E. Brown, M.D.

Norman B. Rosen, M.D.

Leo M. Rozmaryn, M.D.

Charles E. Silberstein, M.D.

Advisory members

Sandra Bishop, M.S.

Ruth Drucker

David Fetter

Committee on Medicine and Religion

Mr. President and Members of the House of Delegates:

The Committee on Medicine and Religion was pleased to present the Prayer Breakfast at the 194th Annual Meeting held at the Omni Hotel in Baltimore City. Clyde R. Shallenberger, D.D., director of the Chaplaincy Service, Johns Hopkins Hospital, spoke on "The Physician's Responsibility to Notify the Patient: Duty and Morality." This was a particularly

timely topic in view of the recent implementation of the Patient Self-Determination Act.

Leslie R. Miles, Jr., M.D., chairperson

Ralph E. Libby, M.D.

Robert E. May, M.D.

Robert J. McAllister, M.D.

Rhodora C. Tumanon, M.D.

Gibson J. Wells, M.D.

Committee on Mental Health

Mr. President and Members of the House of Delegates:

The Committee on Mental Health met eight times during the past year.

The committee was pleased to sponsor the presentation, "Micronutrients and Megavitamins: What's New, What's True," at Med Chi's 194th Annual Meeting. The presentation, which was delivered by committee member Arnold Brenner, M.D., was well received.

The committee has begun plans to

resurrect the monthly column, "Today's Psychiatry," in the *Maryland Medical Journal*.

The committee looks forward to a productive 1992-1993 year.

Lino Covi, M.D., chairperson

Arnold Brenner, M.D.

Betty W. Robinson, M.D.

Edward L. Suarez-Murias, M.D.

Leonard M. Zullo, M.D.

Peer Review Committee

Mr. President and Members of the House of Delegates:

The Peer Review Committee is charged with "reviewing the practices of Maryland physicians as referred by the Peer Review Management Committee upon the request of the state of Maryland Board of Physician Quality Assurance ... for the purpose of evaluating the professional, physical, and mental competency of physicians. This review shall include, but not be limited to, the quality of care rendered and shall be conducted within the guidelines set forth in the *Peer Review Handbook*."

In furtherance of this charge, the Peer Review Committee prepared numerous peer review reports during its

1991-92 term. Eleven meetings were held, including seven meetings of the full committee and four subcommittee meetings. Committee members and other physicians also contributed to the committee's work by reviewing and reporting on charts and by conducting office evaluations.

Often the work of the members does not end with the conclusion of the committee's investigation, since additional record reviews and meetings with members of the staff of the attorney general to prepare cases for legal action also may be required. The seriousness of the cases that are referred to the committee is evidenced by the fact

that over one-fifth of the physicians on whom reports were prepared in calendar year 1991 were charged with violation of the Medical Practice Act.

A major concern of the committee has been improving the speed with which peer reviews are conducted and reported back to the Board of Physician Quality Assurance (BPQA), while preserving both fairness and quality in the review process. To this end, the committee has worked on streamlining the peer review process through such devices as specialty subcommittees. These attempts appear to be substantially improving the quality and promptness of the reports produced.

The committee regularly uses non-member physicians as specialty consultants in each review. The committee always needs additional reviewers and welcomes any volunteers who wish to assist in this important work.

My sincere thanks to the dedicated members of this committee, to our many specialty consultants, and to the Med Chi staff for their support and assistance during this very busy year.

Sidney B. Seidman, M.D., chairperson

Fritz Apollon, M.D.

Amir S. Banisar, M.D.

David M. Cook, M.D.

Augusto R. DeLeon, M.D.

Liebe S. Diamond, M.D.

Henry J. Farkas, M.D.

William N. Fitzpatrick, M.D.

John G. Frizzera, M.D.

Bernard A. Heckman, M.D.

A. Clark Holmes, M.D.

Victor R. Hrehorovich, M.D.

James W. Karesh, M.D.

Charles W. Kinzer, M.D.

Alfred L. Lapin, M.D.

M. Isabelle MacGregor, M.D.

Gerald N. Maggid, M.D.

George S. Malouf, Jr., M.D.

Eugene McNinch, M.D.

Stanley L. Minken, M.D.

William I. Smulyan, M.D.

Larry A. Snyder, M.D.

Paul D. Sullivan, M.D.

Larry G. Tilley, M.D.

Richard L. Wolfe, M.D.

Peer Review Management Committee

Mr. President and Members of the House of Delegates:

The Peer Review Management Committee (PRMC), in existence since June 1989, has continued its function of overseeing the peer review process as specified in the *Peer Review Handbook for Maryland*. The committee meets monthly and is responsible for the following duties:

- Receiving and recording cases referred to Med Chi by the Board of Physician Quality Assurance (BPQA).
- Identifying the guidelines used in conducting the review.
- Referring cases to the appropriate medical review committee.
- Developing and maintaining a monitoring procedure allowing for the immediate status determination of a peer review complaint and ensuring the timely completion of the review.
- Reviewing reports received from investigating committees to determine the adequacy of the reports.
- Specifically identifying report inadequacies in writing and returning inadequate reports to the review committee.
- Sending adequate reports to the BPQA.
- Sending a copy of the BPQA's final disposition reports to the appropriate medical review committee.
- Identifying areas in which medical review committees need education and arranging to have the necessary education provided.
- Providing organizational assistance to any medical review committee in Maryland.
- Periodically meeting with the BPQA to decide what statistical information is needed by the BPQA, Faculty, and component societies to aid in evaluating and upgrading the review process.

The PRMC provided direction to the peer review committees of the Faculty and component societies on the review of all cases referred to the Fac-

ulty for peer review. Also during the past year, the PRMC, in conjunction with the Executive Committee, coordinated the representation of the Faculty's viewpoint with respect to the BPQA audits conducted by the executive and legislative branches of Maryland state government. We are pleased that the Maryland General Assembly reaffirmed the essential role of physician peer review in the medical discipline process.

The PRMC sought to improve the peer review process by educating peer review groups on the guidelines established in the *Peer Review Handbook for Maryland* for the conduct of review activities. Education included visiting local and specialty society peer review committee meetings, convening a meeting of all peer review chairpersons, and insisting that all reports be in compliance with the *Handbook's* guidelines before being approved for transmittal to the BPQA. The PRMC chairperson also sought to improve mutual understanding between the Faculty and the BPQA by regular attendance at BPQA meetings.

The PRMC also developed a protocol for the peer review of malpractice cases filed in the Health Claims Arbitration Office and referred for investigation by the BPQA.

The chairperson thanks all the members of the committee and Med Chi staff for their efforts and support, which ultimately enabled the PRMC to make a significant contribution to the efficacy and fairness of the review process.

Ronald J. Cohen, M.D., chairperson

Robustiano J. Barrera, M.D.

Pablo E. Dibos, M.D.

Jesse M. Hellman, M.D.

Joseph H. Hooper, M.D.

Michael F. Jaworski, M.D.

Francis C. Mayle, Jr., M.D.

David S. McHold, M.D.

Mark S. Seigel, M.D.

Donald S. Stepita, M.D.

Karl H. Weaver, M.D.

Herbert L. Yonsem, M.D.

Physician/Patient Relations Committee

Mr. President and Members of the House of Delegates:

The Physician/Patient Relations Committee continues to investigate complaints against physicians. These complaints are investigated at the request of the Board of Physician Quality Assurance (BPQA), and the committee submits its findings and recommendations to the BPQA for consideration and disposition.

In addition to conducting investigations, committee members and staff respond to daily inquiries on the practice of medicine and related issues.

This activity is an important part of the committee's goal to improve communications and enhance relations between physicians and their patients.

The dedication and commitment of committee members and staff to the continuation and improvement of the peer review process is deeply appreciated.

Lois E. Wehren, M.D., chairperson
Ido Adamo, M.D.
David S. Davis, M.D., J.D.
Lionel A. Desbordes, M.D.
Jack D. Francis, M.D.

Mary B. Gorman, M.D.
Gay M. Guzinski, M.D.
Joseph H. Hooper, M.D.
Norris L. Horwitz, M.D.
Thomas E. Hunt, M.D.
Danilo G. Lee, M.D.
Robert A. Liss, M.D.
Michael S. Madeloff, M.D.
Albert Nahum, M.D.
Ruben Reider, M.D.
Benjamin Rothfeld, M.D.
Lex B. Smith, M.D.
W. Haddox Sothoron, M.D.
James G. Zimmerly, M.D.

Committee on Physician Rehabilitation

Mr. President and Members of the House of Delegates:

The 1991-1992 year was productive for the Committee on Physician Rehabilitation.

In concert with the Committee on Alcoholism and Chemical Dependency, the Committee on Physician Rehabilitation sponsored a highly successful conference, "Addiction: Prevention, Recognition, and Treatment" which took place on November 16, 1991. A monograph of the conference is being developed.

Outreach presentations continued to be made to hospital medical staffs throughout the state, and to component and medical specialty societies as well. Overall, the presentations have been well received. Outreach efforts included presenting program information to nearly 6,000 people—nearly 4,000 of whom were physicians—at ninety-five different locales.

Developing a one-hour continuing medical education (CME) presentation on physician impairment issues was discussed as the next step in the outreach program. This CME program will be part of an effort to schedule return engagements and to avoid being told, "We just saw your slide show last year." The CME presentation will enable the Physician Rehabilitation Program to offer new information to hospitals, and specialty

and component societies, thereby maintaining contacts and increasing the likelihood of receiving repeat referrals.

The measure of outreach effectiveness lies in the number of concern calls received. A concern call or referral to the Physician Rehabilitation Program instigates the investigation process. In calendar year 1991, there was a 60 percent increase in referrals over 1990. Increasing the number of physicians placed into treatment, can have a direct and favorable impact on the quality of medical care of more patients.

The significant increase in referrals also can be attributed to public relations efforts. In addition to advertisements in the *MMJ* and the excellent reviews of our annual drug conference, 150,000 copies of *STRAIGHT FORWARD*—a newsletter that informs and educates health professionals on issues of substance abuse—have been distributed. The Physician Rehabilitation Committee also coordinated the April 1992 issue of the *Maryland Medical Journal*.

In January and February of this year, the Physician Rehabilitation Program underwent a painstaking audit by the Maryland State Division of Audits. For six weeks, legislative auditors pored over the documentation for ex-

penditures of funds obtained from physician license fees for the purpose of operating the Physician Rehabilitation Program. Though we have not yet received a final report, we have been told verbally that the Physician Rehabilitation Program funds were appropriately utilized. Also, on September 10, 1991, Dr. J. David Nagel, then President of Med Chi, signed a memorandum of understanding outlining the handling of cases referred to the committee by the Board of Physician Quality Assurance (BPQA). BPQA referrals comprised about 10 percent of all FY1991 referrals.

The committee looks forward to co-sponsoring another addiction conference, the "Third Annual Conference on Addiction: Physician Health and Education," in the fall of 1992.

The Physician Rehabilitation Committee is pleased with the advances made in the past year, and the members look forward to continued growth in the next.

Stanley R. Platman, M.D., chairperson
William E. Abramson, M.D.
Frederick P. Alpern, M.D.
Federico G. Arthes, M.D.
Leroy C. Bell, M.D.
Nathan L. Centers, M.D.
Mrs. Jacqueline Chang
Morris Z. Effron, M.D.

Committee Reports

Juan G. Gan, M.D.
Georgina Y. Goodwin, M.D.
Cyril G. Hardy, M.D.
Beadia H. Hill, M.D.
Susan J. Kalia, M.D.
Robert R. Kent, M.D.
Edward J. Kitlowski, M.D.

Edward J. Kowalewski, M.D.
Christie G. Lamping, M.D.
Robert M. Marine, M.D.
Dan H. McDougal, M.D.
Patricia A. McIntyre, M.D.
Donald C. Meek, M.D.
Edson B. Moody, M.D.

Claro L. Pio Roda, M.D.
Michael S. Propper, M.D.
Edward T. Schnoor, M.D.
John R. Steinberg, M.D.
Maxwell N. Weisman, M.D.
Raymond A. Wertheim, M.D.
Curtis Wright, M.D.

Policy and Planning Committee

Mr. President and Members of the House of Delegates:

During the 1991-1992 operational year, the Policy and Planning Subcommittee and Committee met to discuss and develop recommendations for the Faculty's goals and policies. The subcommittee presented its recommendations to the full Policy and Planning Committee.

Several issues were discussed in-depth including

- AMA or senior member representation, his/her voting or non-voting status, and institutional memory contribution to the Executive Committee's leadership role.
- Election of the three at-large committee members by the House of Delegates.
- Procedure for processing recommendations (i.e., the Policy and Planning Committee may submit recommendations directly to the Bylaws Committee without submission through the Council).
- Number of at-large members (three or two) if AMA member is a voting member of the Executive Committee.

- Review of recommendation by Dr. Nagel to abolish the positions of chairperson and vice-chairperson of Council and establish a thirteen-member Board of Trustees. The president would chair all three governance bodies—the Executive Committee, the Council, and the House of Delegates. (The president may have the option of designating the president-elect as chairperson of Council.)
- Authority and function of the Bylaws Committee as defined in the bylaws.
- The selection of alternate councilors for each component society.
- Increasing the membership of the Executive Committee.
- Clarifying and defining the roles of the president and chairperson of Council.

After additional discussions, the committee approved submitting several issues to the Bylaws Committee including expansion of the Executive Committee, clarification of the roles of

certain officers, and establishment of alternate councilors to the Council.

It was the consensus of the committee that continued evaluation be conducted on all of the recommendations developed by the committee.

Joseph S. Fastow, M.D., chairperson

Executive committee

Albert L. Blumberg, M.D.
Carol W. Garvey, M.D.
Reynaldo L. Lee-Llacer, M.D.
J. David Nagel, M.D.
Gary L. Rosenberg, M.D.
Marvin Schneider, M.D.
Jose M. Yosunico, M.D.

Council members

Louis C. Breschi, M.D.
Susan R. Gnamieri, M.D.
George S. Malouf, Sr. M.D.
Francis C. Mayle, Jr., M.D.
Joseph Snyder, M.D.

Members-at-large

Henry P. Laughlin, M.D., Sc.D., Sc.S.D.
Wayne C. Spiggle, M.D.
Paul A. Stagg, M.D.

Committee on Professional Ethics

Mr. President and Members of the House of Delegates:

The members of the Committee on Professional Ethics have been active this past year in helping to educate the medical community about the ethical responsibilities pertaining to physicians, other health care practitioners, and the public.

The committee revised or developed ethical opinions related to fee schedules, government intrusion into physician/patient communications on family planning, forgiveness of co-

payment in medical practice, the use of trade names by physicians, and referrals by physicians to self-owned facilities. Supplements to the *Compendium of Laws, Regulations, Opinions and Policies Governing the Practice of Medicine* in Maryland will incorporate these new policies and opinions.

The committee sponsored an educational program at the Faculty's 1992 Annual Meeting in May on "Ethics of

Dying," with a nationally respected speaker in ethics.

The committee reviewed and commented on various legislative proposals regarding living wills, durable powers of attorney, and withholding/withdrawing life-sustaining medical treatment. The committee also worked with the Legislative Committee and the Committee on Emergency Medical Services in drafting a meas-

Committee Reports

urc to require emergency personnel to follow "Do Not Resuscitate" orders.

The chairperson would like to express his thanks to the members of this committee who have devoted countless hours to the important work of this committee.

Louis C. Breschi, M.D., chairperson
Sergio Alvarez-Velasco, M.D.
Edilberto Beltran, M.D.
Vincent O. Casibang, M.D.
Jack C. Childers, M.D.
Beverly A. Collins, M.D.
Deogracias V. Faustino, M.D.

Eugene Guazzo, M.D.
Stephen N. Jones, M.D.
Don M. Long, M.D.
Leslie R. Miles, Jr., M.D.
Benjamin Rothfeld, M.D.
Henry Silverman, M.D.
H. Russell Wright, Jr., M.D.

PRO Monitoring Committee

Mr. President and Members of the House of Delegates:

During the past year, the PRO (Professional Review Organization) Monitoring Committee, through its chairperson, has reviewed materials and provided input on the DEMPAQ (Developing and Evaluating Methods to Promote Ambulatory Care Quality) project. This project is a three-year collaborative effort to develop methods to review the care given to Medicare beneficiaries by physicians with office-based practices. Physicians who participated in this project voluntarily submitted the office records of selected Medicare beneficiaries.

Further efforts of the committee focused on obtaining information from the Delmarva Foundation for Medical Care, Inc. (Delmarva) with regard to the following issues:

1. Qualifications of physician reviewers
2. Criteria for evaluating physician reviewers
3. Action taken when there is an aberrant physician reviewer
4. The procedure employed in determining corrective action
5. Issues concerning the review process
6. Information about the SuperPRO

The information obtained from Delmarva provided the committee with new insight into the review process, as well as information concerning physician reviewers and the interventions employed by the PRO.

Most of the committee's activities centered around reviewing cases referred by individual physicians who were assigned quality points by Delmarva. Eleven cases were reviewed by the committee in the last year. The quality points assigned by Delmarva ranged from one point to twenty-five points. In three cases, Delmarva reversed its original decision and removed the quality points assigned to the physicians. In one

case, payment was denied for eight inpatient days. Delmarva reconsidered this case and allowed payment for five days of hospitalization. (The patient had to request reconsideration of the denial of payment for three days' hospitalization.) Specialty input was solicited in one case and the information provided by the Committee on Specialty Societies, which supported the physician's actions, was provided to the physician to support his position. In one situation, Delmarva modified its corrective action plan and made it less stringent. In five of the cases reviewed by the committee, the severity level and quality points were upheld by Delmarva.

While the committee focused much of its energy on specific cases, the Health Care Financing Administration (HCFA) has recently determined that there will be a fundamental change in the way PROs will carry out their responsibilities. Under the Fourth Scope of Work, PROs will begin moving from dealing with individual clinical errors to increasing hospital involvement in correcting problems and addressing questionable patterns of practice and outcome of care. Because HCFA's focus is changing and emphasis is being placed on physician and provider education, the committee is anxious to learn how this change will affect the PRO process.

Physician inquiries concerning quality points, severity levels, the Maryland Quality Panel, corrective action, and sanctions were answered, and appropriate information was forwarded to the physicians.

Another area of concern addressed by the committee was the HCFA "Alert" that was distributed by Delmarva pertaining to outpatient histo-

ries and physicals. Of particular concern was the statement that the nursing assessment form and/or anesthesiologist's notes are not acceptable as a replacement for the physician's history and physical (H&P), even if it is cosigned by the physician. After the committee reviewed this policy, evaluated the effect of this policy in relation to current acceptable medical practice in outpatient departments and facilities, and expressed its concerns to Delmarva and HCFA with regard to this policy, further clarification of the policy was provided. This clarification recognized that physicians can delegate all or parts of the history and physical to other practitioners as authorized under the facility's medical staff bylaws. HCFA stressed, however, that the physician must sign and assume responsibility for each delegated portion. Furthermore, the history and physical must be kept in one place in the medical record and should not be spread throughout the record. On committee recommendation, this information was provided to the component and specialty societies.

The committee continues to focus its efforts on educating physicians about PRO activities.

Robert Ruderman, M.D., chairperson
Angusto R. DeLeon, M.D.
Marion Friedman, M.D.
Vernon M. Gellhans, M.D.
David B. Glasser, M.D.
Howard J. Hoffberg, M.D.
Roland Imperial, M.D.
John B. MacGibbon, M.D.
Karl F. Mech, Jr., M.D.
Julian W. Reed, M.D.
Richard T. Scholz, M.D.
Karl H. Weaver, M.D.
Frederick Wilhelm, M.D.

Committee on Public Health

Mr. President and Members of the House of Delegates:

The Committee on Public Health began the 1991-1992 year by reviewing and discussing the *Report of the Governor's Commission on Health Care Policy and Financing, Joint Interim Recommendations of the Governor's Commission and the Committee on Uninsured Persons and Uncompensated Care*. Many of the issues and concerns presented in the report reflected issues that were being addressed by the Faculty's various committees. The Committee on Public Health focused on access to affordable medical care and insurance coverage, and the committee supported the American Medical Association's "Health Access America" program.

Another pressing issue for the committee concerned biomedical research. After reviewing materials related to biomedical research and animal rights, the committee recommended, and Council approved, that the Faculty distribute information on biomedical research to the entire membership and that the Faculty compile a list of speakers knowledgeable in this subject who

could address related issues and concerns at regional meetings and medical society meetings. Information was distributed, and speakers are available to address these issues.

The Supreme Court's ruling in *Rust v Sullivan*, which determined that federally funded family planning clinics cannot discuss abortion with pregnant women or provide information about where to obtain an abortion, prompted the committee to recommend the following policy statement to the Council with the caveat that this policy statement be made known to Maryland legislators.

Med Chi supports the tradition of free discussion of all aspects of health care. Recent support by the Supreme Court of the administration's order to interfere with a physician and his/her patient in discussing options of health care is contrary to the tradition of the American physician.

The above policy statement was adopted by Council and disseminated to Maryland legislators.

The committee also acted as the

oversight committee for the following subcommittees and ad hoc committees:

- Immunizations and Infectious Diseases Subcommittee
- Infant, Child, and Adolescent Health Subcommittee
- Maternal Welfare Subcommittee
- Sports Medicine Subcommittee
- Ad Hoc Committee on Laboratory Regulations
- Ad Hoc Committee on Medical Radiation and Nuclear Technologist Regulations

Herman C. Maganzini, M.D.,
chairperson

Robert J. Ancona, M.D.
Timothy D. Baker, M.D.
Neil J. Barkin, M.D.
Joyce M. Boyd, M.D.
John B. DeHoff, M.D.
Harrold T. Elberfeld, M.D.
Vincent D. Fitzpatrick, M.D.
Carol W. Garvey, M.D.
Hilary T. O'Herlihy, M.D.
J. Courtland Robinson, M.D.
Michael A. Sauri, M.D.
Eugene K. Sussman, M.D.

Committee on Public Relations

Mr. President and Members of the House of Delegates:

During the 1991-92 year, the Committee on Public Relations openly encouraged more component society participation by extending a special invitation to attend committee meetings and by asking component societies to list our meeting dates in their publications. The committee conducted a survey of all component society presidents and executives to determine what public relations programs should be pursued. As a result of the survey and discussion between committee members, the following programs were to be emphasized:

1. Doctor/Lawyer/Teacher Partnership Against Drugs

2. Public service announcements
3. "Dear Doctor" column

Partnership program

The Doctor/Lawyer/Teacher Partnership continues to be one of the Public Relations Committee's most successful community programs. Through this partnership, doctors and lawyers visit local schools to talk with students about the medical and legal consequences of drug and alcohol use. This year, Med Chi doctor/lawyer partnerships were conducted in Anne Arundel County, Baltimore City, Baltimore County, Harford County, and Prince George's County. Med Chi conducted four training sessions this

year for doctors wishing to participate in the program. The first two training sessions were held for Baltimore County physicians in September 1991. Two more training sessions were held in January 1992 for physicians in Baltimore City. Currently, more than 250 physicians statewide have volunteered for the program. Although a count of the number of classrooms visited is not yet completed, it is estimated that doctor/lawyer teams reached about 7,000 middle school children during the 1991-1992 school year.

Public service announcements

Because demonstrating that physicians are committed and interested in

the community is just as important as providing good medical care, the committee ordered three public service announcements (PSAs) from the American Medical Association. The three messages include an anti-cocaine campaign, "Don't Blow It"; an anti-smoking campaign, "Ashes to Ashes"; and an AIDS prevention campaign, "Play It Safe." By broadcasting these PSAs on local television stations, Med Chi will be providing a valuable service to the community and making people aware that physicians care.

"Dear Doctor" column

The committee began recruiting physicians to contribute to a "Dear Doctor" column to be published as a Med Chi public service in area newspapers. Physicians from every medical specialty have been encouraged to participate in this project, which will help convey critical medical information to the public. Med Chi must collect a number of articles in advance to be considered for publication. Several interested physicians have already contacted the Public Relations Department about this column.

Radio programs

The committee continued producing radio programs for Med Chi physicians. "Consultation, with John Stupak," Med Chi's live call-in show, heard on over fifty radio stations across the country on Sunday mornings, ran through mid-March. John Stupak also hosts Med Chi's Sunday morning "Consultation," a physician interview show on WBAL-AM radio airing at 9:30 a.m. Health-related topics and today's issues are discussed.

In an effort to encourage speakers to participate in the radio programs and to persuade physicians to speak to public groups, the committee ran advertisements for "Consultation" and for Med Chi's Speaker's Bureau in the *MMJ*. As a result, the number of participating physicians rose from over fifty-five last year to over seventy-five this year.

Annual meeting

In an effort to help physicians understand the benefits of using mass media to convey medical information to the public, the committee sponsored a session entitled "Physicians and the Media" during the 1992 Med Chi Annual Meeting. J. Leonard Lichtenfeld, M.D., F.A.C.P., discussed "Conveying Medical Information to the Public," and Simeon Margolis, M.D., professor of medicine, Johns Hopkins University School of Medicine and columnist for the Baltimore *Sun*, examined the issue of "Improving Communication with Patients and the Community."

Baltimore Harbor Endowment, "Piece of History"

Also during the annual meeting, the committee sponsored the sale of bricks to create a special section in the Broadway Pier Plaza brick walkway in Fells Point dedicated to physicians and Med Chi. The bricks were sold for \$50 each and will be placed in a special grouping around an oversized brick bearing Med Chi's name and message. This project provided Med Chi with a permanent message that can be used for public relations purposes and created a place for the organization in Maryland history.

Awards

The committee continued to sponsor its awards programs, including the Wyeth-Ayerst Laboratories Physician Award for Community Service. Formerly the A.H. Robins Award, the award is presented each year to a physician who has provided outstanding service to his or her community outside the field of medicine. Clifford G. Andrew, M.D. received the 1992 award during the 1992 Med Chi Annual Meeting for his commitment to protect our country's most precious and endangered air, water, land, and wildlife resources.

The Third Annual Award for Excellence in Organized Medicine, an award created to encourage medical

student involvement in organized medicine, was also presented during the annual meeting. William David Sullivan from the Johns Hopkins School of Medicine was the recipient.

The Public Relations Committee sponsored the Twelfth Annual Photo Contest. Faculty and Auxiliary members entered over twenty photos, which were judged by Isaac Jones, a professional photographer from Baltimore. Michael A. McClinton, M.D. won first place and David Paul, M.D. won second place. All entries in the photo contest were on display during the annual meeting.

Certificates of recognition were presented, during the House of Delegates session of the annual meeting, to three physicians for their outstanding service and dedication as chairpersons of Med Chi committees. President J. David Nagel, M.D. presented certificates to Ronald J. Cohen, M.D., chairperson, Peer Review Management Committee; Edward J. Kowalewski, M.D., chairperson, Focused Professional Education Committee; and Hiroshi Nakazawa, M.D., chairperson, Public Relations Committee.

This year the committee continued to promote longstanding programs and was successful in initiating several new programs that enhance the image of physicians in the community. The committee welcomes comments and suggestions from Med Chi members on all its activities. As chairperson, I thank the members of my committee and all participating physicians whose time and effort have made this a productive year.

Hiroshi Nakazawa, M.D., chairperson

John W. Buckley, M.D.

K.G. Dritsas, M.D.

Vincent D. Fitzpatrick, M.D.

Rafael C. Haciski, M.D.

F. Christian Hansen III, M.D.

Thomas F. Krajewski, M.D.

Gary W. Pushkin, M.D.

Ibrahim A. Razzak, M.D.

Gholam R. Sadjadi, M.D.

Robert B. Shocket, M.D.

Advisory member

Victoria Cameron

Committee on Scientific Activity

Mr. President and Members of the House of Delegates:

This year, the Committee on Scientific Activity recommended that bylaw changes be adopted to concentrate the committee's focus on the design, development, and presentation of the Faculty's continuing medical education (CME) activities. The bylaw changes were approved by the House of Delegates at its meeting on April 30, 1992. The committee will now be able to fully comply with the *Essentials and Guidelines for Accreditation of Sponsors of Continuing Medical Education* promulgated by the Accreditation Council for Continuing Medical Education—the organization that accredits sponsors for physicians' CME activities nationally.

During the year, Med Chi developed activities earning 75 credit hours

in Category 1 of the Physician's Recognition Award of the American Medical Association. These included

- Med Chi's 1991 Semiannual Meeting in Ocean City
- The president's regional meetings
- The second annual drug conference, "Addiction: Prevention, Recognition, and Treatment"
- "Performing Arts Medicine: Issues in Diagnosis and Treatment"
- "Tobacco Use During Pregnancy"
- "Alcohol and Drug Use During Pregnancy"
- Med Chi's 1992 Annual Meeting at the Omni Hotel in Baltimore

Also, as part of its activities, the committee has sponsored programs with the Baltimore City Medical Society, the Baltimore County Medical As-

sociation, the Medical Mutual Liability Insurance Society of Maryland, and the Maryland Society of Eye Physicians and Surgeons, making available 16.5 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

Jose Martinez, M.D., chairperson

Benjamin V. Del Carmen, M.D.

Gershon Efron, M.D.

Victor R. Hrehorovich, M.D.

J. Richard Lilly, M.D.

Walker L. Robinson, M.D.

Advisory members

Marianne U. Chiccone, D.M.D.

Vivian Lynn

Committee on Specialist Identification

Mr. President and Members of the House of Delegates:

The Committee on Specialist Identification held seven meetings this past year to implement the mandated specialist identification authority of the Board of Physician Quality Assurance (BPQA). This committee functions as the reviewing body for the BPQA on applications received from physicians requesting designation in a particular medical specialty.

Application for specialty designation is open to all licensed physicians in Maryland. If a physician is certified by the American Board of Medical Specialists, the identification is automatically given by the BPQA upon confirmation of that credential.

If not certified by the American Board of Medical Specialists, the phy-

sician must complete an application outlining specific training and experience in the particular specialty.

The applications are referred by the BPQA to this committee for evaluation. Criteria used for such evaluation were developed jointly by Med Chi and the BPQA and are set forth in administrative regulations (COMAR 10.32.08) having the force and effect of law. The BPQA makes the final decision on the basis of the recommendation from the committee. The identification is permanent, and the physician may publicize himself or herself in the given area of specialty.

Much time and effort has been exerted in reviewing the 2,724 applications received thus far. Of the

applications reviewed, the committee has recommended that 200 be denied. Each application is reviewed thoroughly, fairly, and in strict compliance with the required criteria.

I wish to thank the members of the committee for their patience in carrying out this mandated function.

Samuel D. Friedel, M.D., chairperson

William A. Crawley, M.D.

Willarda V. Edwards, M.D.

Donald W. Kress, M.D.

Joseph S. McLaughlin, M.D.

B. Martin Middleton, M.D.

Hiroshi Nakazawa, M.D.

Arthur W. Sagoskin, M.D.

David P. Zajano, M.D.

Committee on Specialty Societies

Mr. President and Members of the House of Delegates:

The Committee on Specialty Societies is comprised of representatives (chosen by the Faculty president) from various Maryland specialty societies. The committee is charged with reviewing issues concerning interdisciplinary and multidisciplinary problem areas of medical practice as they relate to each specialty. The committee provides specialty representation on the Council and the House of Delegates.

During the 1991-1992 year, the committee held four meetings at which the following issues were raised.

The committee investigated the subject of payment for ulnar nerve decompression as referred by the Committee on Managed Care and Third-Party Liaison. After receiving expert opinions from specialists in the field, it was the decision of the committee to not recommend reimbursement for the procedure.

As requested by Med Chi's PRO Monitoring Committee, the Committee on Specialty Societies examined the use of Ativan as a PRN (as needed) medication. The committee concluded—upon advisement by the Committee on Pharmacy and Therapeutics of the Maryland

Psychiatric Society—that, based upon the information provided, the use of Ativan as a PRN was substantiated in the particular case presented.

After reviewing the Americans with Disabilities Act (ADA) and its impact on physicians, the committee recommended that the Maryland Occupational Medical Association prepare a letter for dissemination of ADA information to each specialty society.

Criteria for membership on the committee is currently being discussed. This issue will be further discussed at a reference committee meeting, and suggested criteria will be presented to the House of Delegates at its September 1992 meeting.

J. David Nagel, MD, president, addressed the committee at its January meeting and informed the committee that he would welcome recommendations regarding the issue of practice parameters.

Throughout the year, the committee was kept abreast of a number of issues of concern to Med Chi members including radiation and laboratory technologist regulations, the Health

Care Financing Administration's (HCFA's) global surgery policy, the Resource-based Relative Value Scale (RBRVS), Medicaid's Provider Fee Program, the utilization review of managed care organizations, and other items from the Ad Hoc Therapeutic and Formulary Committee.

Jay Gerstenblith, M.D., chairperson

Paul Bormel, M.D.

George H. Brouillet, M.D.

James Castellano, M.D.

Enzo Cosentino, M.D.

Maurice B. Furlong, M.D.

Edward J. Goldman, M.D.

Neil A. Green, M.D.

Lee E. Gresser, M.D.

Bruce A. Hershfield, M.D.

Charles F. Hobelmann, M.D.

William R. Leahy, M.D.

Kenneth B. Lewis, M.D.

Christian S. Mass, M.D.

Dean L. Mondell, M.D.

David C. Moses, M.D.

Lawrence C. Pakula, M.D.

Robert J. Spence, M.D.

Allan P. Weksberg, M.D.

Richard B. Williams, M.D.

Ad Hoc Therapeutic and Formulary Committee

Mr. President and Members of the House of Delegates:

The Ad Hoc Therapeutic and Formulary Committee was established as a standing committee on May 2, 1992. The committee's name was changed to the Therapeutic Education Committee to reflect the committee's focus, which is to develop informational and educational programs for physicians on effective and cost-efficient prescribing practices. The committee will aid the Medical Assistance Program in analyzing the effectiveness of "therapeutic formularies" and endeavor to ensure that any preauthorization mechanism is acceptable to the Faculty. The committee will cooperate with government and private agencies

working in the pharmaceutical field and may invite physician and non-physician members of such agencies to work with the committee on a nonvoting basis.

During the 1991-1992 year, the ad hoc committee initiated a number of educational activities from presenting scientific programs to drafting a therapeutic drug use newsletter.

The committee sponsored a scientific program, "Optimizing Drug Therapy Outcomes in Maryland—The Time is NOW," at Med Chi's 193rd Annual Meeting in College Park, Maryland. For the 194th Annual Meeting, the committee sponsored, "Efficacy vs

Expense: Maximizing Drug Therapy Outcomes in Your Patient," at the Omni Hotel in Baltimore. Additionally, as part of the committee's educational outreach efforts, "Improving Drug Use" was presented to the residents at St. Agnes Hospital. The presentation was well received and plans are underway to offer it elsewhere. The program is seen as an opportunity to positively influence prescribing practices of young physicians.

With approval from the Executive Committee, the ad hoc committee designed, for distribution to physicians providing care for Medicaid patients, a newsletter on therapeutic drug use

entitled *EQUAL=TIME, Prescribing with the WHOLE Story*. The committee will continue to draft and disseminate newsletters addressing this topic.

The ad hoc committee discussed the Department of Health and Mental Hygiene's (DHMH's) proposal to not cover or to limit Medicaid coverage of

an entire classification of drugs, such as the benzodiazepines and barbiturates. The matter was forwarded to the Executive Committee for further discussion and action.

Richard M. Susel, MD, chairperson
Louis C. Breschi, M.D.
Ronald Goldner, M.D.

James C. Kleeman, M.D.
John O. Meyerhoff, M.D.
Joshua R. Mitchell, M.D.
Robert Ruderman, M.D.
Gita K. Shah, M.D.

Advisory members
Gary L. Rosenberg, M.D.
Nancy Yamanaka-Yuen, Pharm.D.

Women in Medicine Ad Hoc Committee

Mr. President and Members of the House of Delegates:

Due to the ever present need to recruit women physicians to participate in organized medicine and because of the special gender issues in medicine that should be regularly addressed, the Women in Medicine Ad Hoc Committee became a standing committee of the Faculty during the 1991-92 year.

The committee worked to fulfill three goals:

1. Promote women's health issues
2. Increase women's participation in Med Chi
3. Support and promote child care and elder care programs

To fulfill its primary goal of promoting women's health issues, the committee cosponsored "The Battered Women Syndrome" during the Med Chi 1992 Annual Meeting. During the session, Ellen McDaniel, M.D., a general and forensic psychiatrist; Judy Wolfer, director, Domestic Violence Clinic for the House of Ruth; Jann Jackson, associate director of the House of Ruth; and Sallie Rixey, M.D., assistant director, Department of Family Practice, Franklin Square Hospital, worked together to increase awareness of the physical and emotional symptoms of women involved in domestic violence.

The committee also responded to inquiries from health care consultants, providing topics that should be addressed in seminars for women in the medical profession.

To meet its second goal of increasing women's participation in Med Chi, the committee worked diligently to increase its own committee participation and succeeded by significantly raising average meeting attendance. As a result, many new ideas were exchanged. In addition to the increase in committee participation, Med Chi saw an increase of approximately ninety-six new women physician members since May 1991.

To fulfill its third goal, the committee concentrated on promoting elder care programs and, as a result, initiated a program benefiting all Med Chi members. This new program gives Med Chi physicians access to Maryland Elder C.A.R.E., a service not available to the general public. Because planning for the complex needs and responsibilities of elderly relatives can be time-consuming and confusing, Maryland Elder C.A.R.E. provides the following timesaving conveniences:

1. Personalized assessments of an elderly person's needs by experienced gerontologists. This service is available by phone five days a week; the staff provides an assessment within two working days.
2. An elder care handbook, which reviews issues and options in caring for the elderly.
3. Information on resources for the elderly, such as home health services, transportation services, housing alternatives, hospitals and respite care,

nursing home services, insurance, and financial and legal services.

4. Access to more than 3,000 local and regional gerontological resources with individualized referrals to these resources.
5. Strict quality control procedures.

Med Chi members who use Maryland Elder C.A.R.E. pay a service fee of \$125 for a professional phone consultation. A second phone session for the same elderly person costs only \$95. In-person consultations are also available.

The committee is planning a regional meeting of women in medicine committees, which would provide an opportunity to share experiences and ideas with professionals from other states.

The members of the committee thank Med Chi for the opportunity of serving on this committee. We welcome any comments or suggestions for future activities from all physicians.

Esther Edery, M.D., chairperson
Marianne Benkert, M.D.
Joyce M. Boyd, M.D.
Jaleh K. Daee, M.D.
Susan R. Gnamieri, M.D.
Hilda I. Houlihan, M.D.
Susan W. Owens, M.D.
Mahim Shamszad, M.D.
Beverly J. Stump, M.D.
Rhodora C. Timanon, M.D.
H.M. Zassenhaus, M.D.

Committee on Young Physicians

Mr. President and Members of the House of Delegates:

During the 1991-1992 year, the Committee on Young Physicians focused on expanding its membership and recommended to the Executive Committee that members be solicited from all the component medical societies. The Executive Committee approved this recommendation and solicited names of members for the Committee on Young Physicians.

The committee continued its efforts to gather information on businesses that would be willing to offer services, equipment, and supplies to young physicians at a discount rate. Completion of a brochure listing these businesses is projected for the near future.

Furthermore, the committee investigated various seminars and workshops that could be offered to young

physicians to assist them in their practices. This effort is being coordinated with the Faculty's Department of Continuing Medical Education.

Another important activity of the committee was a letter-writing campaign to federal legislators in support of the American Medical Association's efforts to repeal inequitable Medicare payment cuts for "new physicians." Under the current legislation, new physicians, with limited exceptions, are paid 20 percent less by Medicare on a per service basis in the first year of practice, 15 percent less in the second year, 10 percent less in the third year, and five percent less in the fourth year of practice. This type of reimbursement arrangement discriminates against young physicians and

violates the concept of Medicare payment differentials being determined on the basis of resource costs, which is a concept adopted by Congress in landmark payment reform. The effort by committee members to contact members of Congress prompted positive responses from Maryland legislators.

Scott M. Rifkin, M.D., chairperson

Carlos A. Alarcon

Eileen D. Ebert, M.D.

Rafael C. Haciski, M.D.

Brian E. Mondell, M.D.

Mike Mussumi, M.D.

Eric A. Oristian, M.D.

Marcel E. Salive, M.D.

Philip L. Schneider, M.D.

Emily J. Windham, M.D.



PHYSICIAN'S RECOGNITION AWARD

During May and June 1992, the physicians listed below received the American Medical Association's (AMA's) Physician's Recognition Award. Established in 1968, the award's purpose is to encourage physician participation in continuing medical education and to recognize those physicians who have voluntarily completed programs of continuing medical education.

Steven Jeffrey Adashek
Richard Joel Bass
Gabriel Berrebi
Tracy Marie Black
George Bolen
Simon Calle
Judith M. Chertoff
William Paul Ciesla
Allan Barry Cohan
Gregory Paul Connors
Joesph David Croft
Wilhelmina M. Cruz
Kirk David Denicoff
Allen Clark Egloff
Sanford H. Eisenberg
Stephen Epstein
William Whately Fore
Lesley A. Fraser

Vinu Ganti
Craig Erwin Geist
Linda Lee George
Andres Gonzalez-Barreto
James Larrabee Hatleberg
Bernard Alvin Heckman
Alan Louis Heine
Sherilynn Joan Hummel
Thomas Gregory Johnson
Earlene Jordan
Raja Kandaswamy
William Ralph Kanter
Leeds Edward Katzen
Harry L. Knipp
Gregorio Koss
Donald W. Kress
Ramsy Selim Labib
Dale Nolan Lawrence

Angelo John Lucco
Csaba Ladislao Magassy
Lawrence Maryanov
Brian Gerard McAlary
Darrell Winfred McIndoe
John Robert McLean
Roy Aaron Mark Myers
Vincent Nguyen
Guillermo Olivos
Lawrence Charles Pakula
Gary Charles Prada
Jeffrey Louis Presser
Frederick Stanley Raines
Nasser Rezai
Manuel A. Rivero
Eli J. Roza
David Samuel Scharff
Christopher M. Schemm

Reinhardt Hans Schindler
Allan Z. Schwartzberg
Michael Louis Sherman
Laurie J. Hedrick Smith
Neil Spiegel
John Robert Starynski
Irene Gorski Tamagna
David J. Thaler
Clifford James Turner
Vanessa Valencia-Wilson
Enrico Paul Veltri
John Marc Wigginton
Irving Darryl Wolfe
Stewart MacKay Wolff
Gazi B. Zibari

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GET POLITICAL!**

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physicians support the political activity
that benefits all physicians?

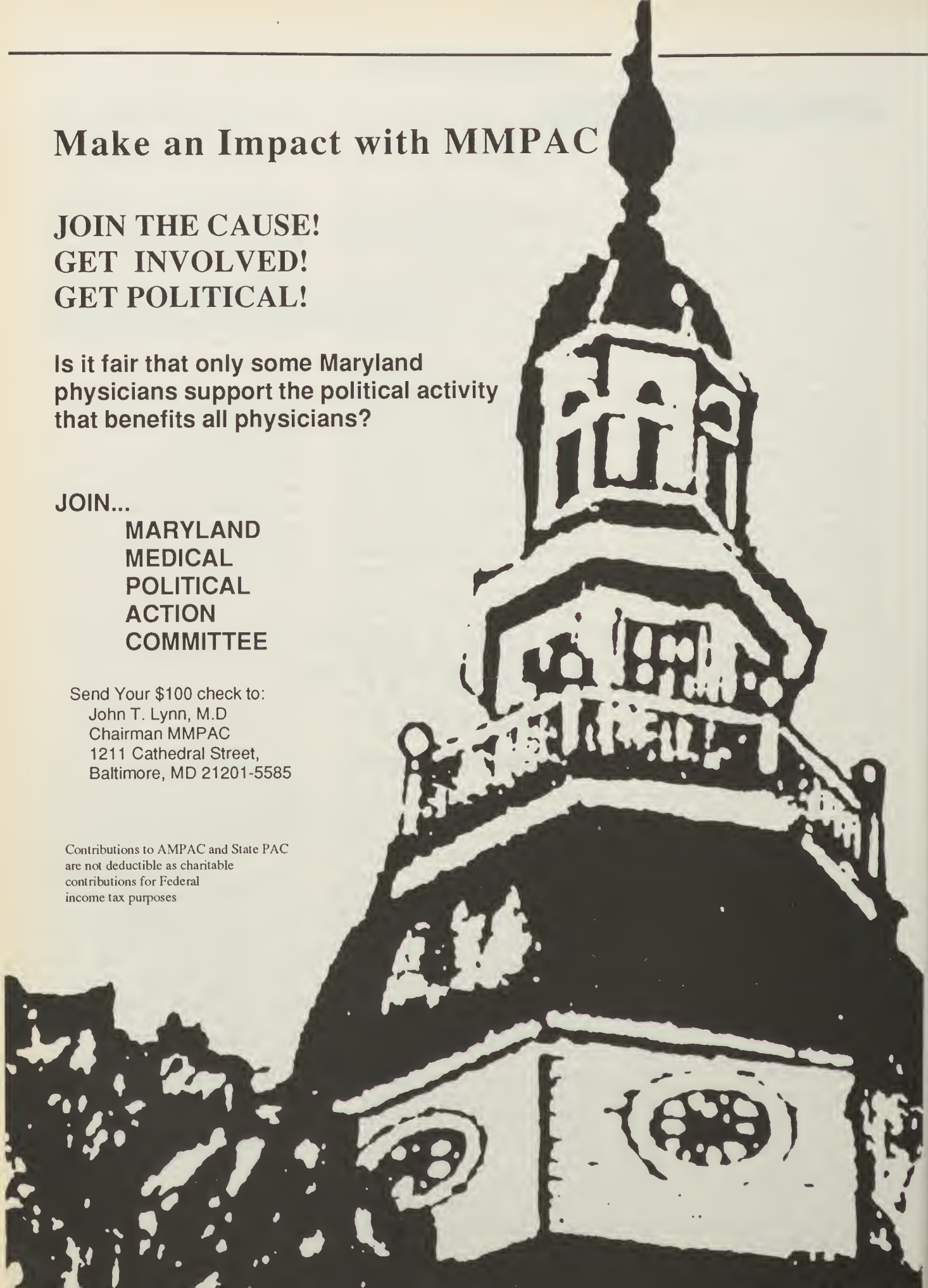
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POLITICAL
ACTION
COMMITTEE**

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John T. Lynn, M.D.
Chairman MMPAC
1211 Cathedral Street,
Baltimore, MD 21201-5585

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income tax purposes



AMA-ERF Report

Mr. President and Members of the House of Delegates:

It is with much pleasure that I present this report of Faculty members' contributions to the cause of medicine in Maryland via AMA-ERF (American Medical Association Education and Research Foundation).

The generosity and staunch support of Med Chi Faculty members will be welcomed by the deans of the designated medical schools. For, as you know, the "flexible funds" of AMA-ERF help to sustain and maintain a degree of excellence that all 164 accredited US medical schools strive to achieve.

With federal and state funding now slashed to the bare bones, this medical family program is specifically designed to help meet the ever-increasing needs of our medical schools. Yet, unlike any of the major charities, not one penny is ever shaved off for salaries, postage, or other operational expenses.

Dr. Nagel, I respectfully urge you, using the power of your office, to emphasize the importance of the AMA-ERF program and further encourage Faculty members' continued support. Your cooperation will be deeply appreciated.

Thank you for affording me the privilege of serving the Faculty in the capacity of AMA-ERF chairperson during your tenure in office.

Faculty contributions June 1, 1991 - March 31, 1992

Allegany County	\$ 640.00
Anne Arundel County	1 ,560.00
Baltimore City	4,245.00
Baltimore County	3,695.00
Calvert County	140.00
Caroline County	---
Carroll County	260.00
Cecil County	80.00
Charles County	160.00

Dorchester County	100.00
Frederick County	420.00
Garrett County	40.00
Harford County	740.00
Howard County	760.00
Kent County	120.00
Montgomery County	5,840.00
Prince George's County	2,500.00
Queen Anne's County	20.00
St. Mary's County	---
Somerset County	---
Talbot County	680.00
Washington County	940.00
Wicomico County	1,060.00
Worcester County	40.00
Total	\$24,040.00

Maryland physicians' direct contributions

June 1, 1991 - March 31, 1992

\$ 7,305.00

Elizabeth A. Linhardt, state chairperson

Auxiliary Report

Mr. President and Members of the House of Delegates:

It has been both a privilege and an honor to have been the State Auxiliary president this past year. One of my many privileges has been working with an outstanding board of directors. They have given me the support, the knowledge, and the insight into my position that I needed to fulfill my job. It has been an honor to represent the State Auxiliary in all my travels and at all my meetings. It has been a challenge, and I would not have been able to complete this year without the help and support of the State Auxiliary's members. This past year has made me stronger, I think—wiser, and I hope more understanding. It has been a year I shall not forget.

My year began with traveling to all the counties to install the new officers. It was truly wonderful to meet auxiliary members from across our state and to see their dedication and the hard work they are devoting to community

health projects, health education, and fund-raisers for AMA-ERF (American Medical Association Education and Research Foundation) and other community needs. We really have a most *diverse* and *talented* volunteer organization.

In June, I headed the Maryland delegation at the annual meeting of the AMA Auxiliary in Chicago. It was exciting to attend the annual convention and to be able to meet with and get to know auxiliary members from across the nation. Later in the fall, I was privileged to again attend Confluence, but this time as the state president. The classes that I took helped me to understand my role as president, and they increased my knowledge of the auxiliary and its function and role.

This year, our state health project has been "Breast Cancer Awareness." At our fall House of Delegates meeting, we were able to devote two days

to this project. We heard about the Reach for Recovery program, and we saw videos on breast self-examination. Our knowledge was increased about mammography, and we were taught how to perform breast self-exam on synthetic models. At our winter board meeting, we continued our study of "Breast Cancer Awareness" by learning more about the mobile mammography van that is sponsored by the University of Maryland Medical Center. At our annual meeting in Baltimore, the Auxiliary was able to tour the van.

Because of scheduling difficulties and John's (my husband's) illness and surgery, I was unable to attend many of the out-of-state meetings. Our president-elect, Myrna Goodman, represented me at some of the meetings I was unable to attend. It has been a wonderful experience working with Myrna. She is always cooperative and

Executive Director's Report

eager to learn. I know she will make an outstanding state president.

Our Long-Range Planning Committee was very active this year. We were able to redefine our purpose and our goals. We talked about changing a few of our bylaws, one concerning the Nomination Committee, which suggested that all component presidents be given the opportunity to serve on the state level at the completion of their term.

On March 13, 1992, I represented the State Auxiliary at the State House in Annapolis. There we were presented with the Doctor's Day proclamation signed by Governor William Donald Schaefer. Maryland Doctor's Day was celebrated on March 30th—National Doctor's Day.

Our component auxiliaries were very active in health projects and fund-raising. The components raised money for AMA-ERF, scholarships, hospice, food baskets for the needy, free mammograms for the needy, health care for the homeless, sports equipment, and trips to camp—these are just to name a few.

We sponsored health fairs for the elderly, taught aerobics to seniors, took "Organ Annie" to elementary schools, made "baby bundles" for needy parents, organized a children's health and safety fair, made bed caddies for a nursing home, and presented the "magic school bus inside the human body" to over 500 children and adults. The list goes on and on. We are indeed a very active state medical auxiliary.

In closing, it has been a pleasure to work with Dr. J David Nagel, president of Med Chi, and Dr. Jose Martinez, chairperson of the Scientific Activity Committee. I would like to thank them for their help and support. I also want to thank the Med Chi staff and its executive director, Mr. Angelo Troisi, for their continued support and assistance. Last but not least, I would like to thank JoAnn Troisi, our State Auxiliary's executive director. JoAnn has kept me on the right path and headed in the right direction, and I am proud to call her my friend.

Vivian Lynn, State Auxiliary president

Mr. President and Members of the House of Delegates:

With the guidance and support of its membership, Med Chi faced a myriad of issues this year, many of which were brought on by increases in government regulation and a growing concern for national health care reform. This report highlights several of Med Chi's achievements during 1991-1992.

1992 legislative session

Med Chi took a very active role during the 1992 session of the Maryland General Assembly. Physicians on Med Chi's Legislative Committee were very informed of activity in Annapolis this year because of Med Chi's *Legislative Update*, a weekly newsletter that summarized activities in the General Assembly.

To demonstrate Maryland physician support of health care legislation this year, Med Chi held a legislative rally for physicians on March 4, 1992. Following the rally, many physicians spent the day talking with their representatives about pending legislation, while others testified at legislative hearings. For a more detailed account of the 1992 legislative session, see the Legislative Committee report.

Human immunodeficiency virus

The regulation and testing of persons for human immunodeficiency virus (HIV) was the subject of a number of bills introduced this year. Prior to the session, Med Chi sent a series of letters to legislators in an effort to educate them about HIV transmission. The letters were also intended to show that the mandatory testing program for health care workers proposed by Governor Schaefer is not a cost-effective way to deal with HIV.

In September 1991, the Med Chi House of Delegates adopted the *Practice Protocol for Physicians with HIV* as part of a legislative mandate to develop a report on the issue of HIV-positive physicians. Created by the Med Chi Committee on AIDS, in consultation with the Maryland Hospital Association (MHA) and the Department of Health and Mental Hygiene

(DHMH), the protocol is a mechanism by which Med Chi can evaluate the practice patterns of HIV-positive physicians and set limits for their practice if necessary. In December 1991, Med Chi presented the protocol to the House Environmental Matters Committee. Although the protocol was not included in any legislation passed during the 1992 session, it is still a Med Chi policy.

At the federal level, following the passage of an AIDS (acquired immunodeficiency syndrome) bill in the US Senate that would impose a ten-year minimum prison sentence on health care workers infected with HIV who provide treatment without disclosing their HIV status, Med Chi sent letters to all US representatives and senators from Maryland urging them to vote against such legislation. The measure was later defeated.

Board of Physician Quality Assurance

The future of the Board of Physician Quality Assurance (BPQA) was also a focal point during the 1992 legislative session. In December 1991, Med Chi received a copy of the fiscal services department's audit of BPQA operations. The audit was conducted in accordance with Maryland law stating the BPQA would go out of existence on July 1, 1993 unless the Maryland legislature passed legislation stating otherwise.

A joint subcommittee of the House Environmental Matters Committee and the Senate Economic Affairs Committee reviewed the recommendations made by the audit in January 1992. The subcommittee upheld several of the audit's recommendations, while it rejected others that would not benefit the BPQA process. One significant recommendation rejected by the subcommittee was the proposal to assign standards of care cases to outside independent reviewers rather than to Med Chi for peer review. Med Chi played a vital role in convincing the joint subcommittee that the preserva-

tion of peer review was essential to the BPQA process. After completing the review, the subcommittee drafted legislation to be introduced to the 1992 General Assembly.

When the Maryland House and Senate passed the bill, the life of the BPQA was extended until the year 2003. While the new law allows for the continuation of peer review, it also grants the BPQA the authority to assess civil fines on licensed physicians. The BPQA may use the fines as grounds for discipline only in cases that do not involve standards of care or competence. Med Chi encouraged the passage of amendments that require that the fines collected be paid to the General Fund, rather than directly to the BPQA.

Physician licensure fees

Because the BPQA is now regarded as a fiscally autonomous entity, it was granted authority to increase physician licensure fees under an emergency regulation during September 1991. Although Med Chi testified against the institution of the emergency regulation and against the BPQA's proposal to make the increase a permanent change, the BPQA stated it needed additional revenue to cover operating costs. The new licensure fees became permanent on January 2, 1992.

Self-referral

Another predominant issue during 1991-1992 involved physician self-referral to a health care facility in which the physician has an ownership interest. Beginning July 1, 1991, Maryland law requires physicians to post a notice in their office regarding the ownership of other health care services to which physicians refer patients. To help Maryland physicians comply with this new law, Med Chi published disclosure of ownership signs in the *Maryland Medical Journal*.

In December 1991, the American Medical Association (AMA) passed a report by its Council on Ethical and Judicial Affairs stating that, in general, physicians should not engage in self-referral. Although there were several

exceptions to this rule, many physicians believed the new policy was too restrictive.

In addition to the new AMA stance, HB 1374—a bill that would have prohibited physicians from referring patients to health care facilities in which the physician or a member of the physician's immediate family had a financial interest—was introduced during the 1992 session of the Maryland General Assembly. The bill did not pass because agreement could not be reached in the final days of the session.

In June 1992, the AMA House of Delegates voted to soften its previous stance on self-referral. The new AMA position states that physicians may ethically refer patients to facilities in which they have an ownership interest as long as they inform their patients.

In July 1992, the Med Chi Ethics Committee reviewed the issue of self-referral and recommended that Med Chi oppose further legislation restricting self-referrals and/or investments, and that Med Chi adopt a position dealing with self-referral that can be enforced by the medical community. Although no position has been developed as of August 1992, Med Chi will be following this issue closely during the coming year.

Mammography screening

Because of legislation passed during 1991 (HB 408), Med Chi focused on mammography screenings in 1991-1992. The new law requires physicians, who perform mammography screenings, to obtain accreditation from the American College of Radiology (ACR) or from the Health Care Financing Administration's (HCFA's) accreditation program. The legislation also charged Med Chi, the Maryland Radiological Society (MRS), and DHMH to develop a third accreditation program for physicians who perform mammography screenings. After reviewing both the ACR and HCFA standards, the Med Chi Public Health Committee determined that these standards were sufficient and recommended that the state not promulgate new and separate standards. A written opinion was presented to the DHMH.

X-ray assistants

Related, in part, to the mammography standards issue is the issue of radiation technologist qualifications. During the 1991 Med Chi Semiannual Meeting, the Med Chi House of Delegates accepted a report on requirements for a new class of x-ray assistant. This report was required by a bill passed during the 1991 session of the General Assembly (HB 408). Med Chi presented the report to the Senate Finance Committee in December 1991 and worked closely with the legislature to ensure the passage of HB 1339. As passed, HB 1339 allows a physician to delegate certain types of x-rays to persons who have successfully completed at least thirty hours of the training approved by the MRS, in consultation with the Maryland Society of Radiation Technologists (MSRT), and who have successfully passed an examination based on the course. Specifically, the x-ray assistant is only permitted to x-ray the chest, spine, and extremities, not including the head. X-ray assistants are not permitted to perform computerized or noncomputerized tomography, fluoroscopy, invasive radiology, nuclear medicine, radiation therapy, or xerography. The new x-ray assistant is exempt from certification requirements for radiation technologists and may be subject to continuing medical education requirements as determined by MRS, in consultation with MSRT.

Smoking

Med Chi continued its efforts to reduce smoking in Maryland by supporting the passage of a twenty cent increase in the excise tax on cigarettes. Med Chi also supported a measure, which did not pass, that would have established smoking and nonsmoking sections in indoor areas to which the public has access.

In addition to Med Chi's efforts in Annapolis, the Med Chi Council affirmed a new "No Smoking" policy within the Med Chi Faculty Buildings in July 1991. The Council also adopted a "No Smoking" policy during

all official events of the Faculty, irrespective of their location (e.g., during annual and semiannual meetings held in public buildings).

Laboratory regulations

In response to the growing concern by Maryland physicians over increasing laboratory regulations, Med Chi formed an Ad Hoc Special Committee on Laboratory Regulations during 1991-1992. This ad hoc committee worked in conjunction with the Maryland Laboratory Advisory Committee (LAC) to revise Maryland's laboratory regulations and address important issues such as regulatory impact on rural practitioners, decreased fees for small office practices, and standard operating procedure manuals. Many of the changes suggested by the ad hoc committee were accepted by the LAC and were developed into proposed regulations.

The Ad Hoc Special Committee on Laboratory Regulations now plans to address the federal Clinical Laboratory Improvement Act of 1988 (CLIA 88) and follow the state's efforts to obtain exempt status under CLIA 88 so that Maryland can keep its control of laboratory testing.

Medical assistance

A new funding program for the Maryland Medical Assistance Program was of concern to many Maryland physicians during 1991-1992.

In July 1991, DHMH Secretary Nelson Sabatini addressed the Med Chi Council and responded to questions from physicians regarding the DHMH-proposed Provider Fee Project (PFP). While this program was in effect, the Bush Administration announced that it would design regulations that would prevent states from implementing the PFP and variations of this program. DHMH and HCFA were on opposing sides of this issue, and physician support of the PFP varied. Therefore, Med Chi did not officially oppose or support the PFP.

Medicare fee schedule

Throughout 1991-1992, Med Chi worked with HCFA and other agencies associated with Medicare to provide physicians with the most current infor-

mation about Medicare and the new fee schedule. Informational bulletins from HCFA and Medicare carriers were published in several issues of the "Executive Director's Newsletter" in an attempt to keep Maryland physicians informed about the latest developments in Medicare and to help ease physicians into the new fee schedule.

In June 1991, Med Chi wrote to Gail Wilensky, administrator for HCFA, to outline several concerns about the implications that the fee schedule will have on medical care. Concerns listed included

- conversion factor,
- global surgery policy,
- limited license practitioner services,
- site of service differentials,
- payment for drugs incident to a physician's services,
- anesthesia services,
- electrocardiograms,
- physicians who assist at surgery,
- payment for services and supplies incident to a physician's service,
- new physician adjustment, and
- consultative pathology services.

A Med Chi letter campaign was initiated, and thousands of our physician members responded. In August, as a result of the enormous input from physicians, the Bush Administration announced that it will revise the Medicare fee schedule that was published in the July 29, 1992 *Federal Register*. The new fee schedule, known as the Resource-Based Relative Value Scale (RBRVS), was intended to impart a more equitable payment system, but actually would have imposed a 16 percent reduction in physician payments.

Current efforts are focused on providing HCFA and the carriers with physician input about the new evaluation and management (E&M) codes and keeping physicians informed about physician payment reform.

OSHA regulations on bloodborne pathogens

In addition to the new Medicare fee schedule, there was also a great deal of attention focused on other national regulations affecting physicians.

As a result of the continued focus on HIV transmission, the Occupa-

tional Safety and Health Administration (OSHA) promulgated regulations, in December 1991, designed to minimize occupational exposure to the hepatitis B virus, the human immunodeficiency virus, and other bloodborne pathogens. To assist physicians in complying with the new regulations, Med Chi developed a model exposure control plan that is available to all Med Chi physicians. In addition, Med Chi is sponsoring training programs for physicians and their office staffs on the new OSHA regulations.

Advance directives

Effective December 1, 1991, the federal Patient Self-Determination Act requires all hospitals, nursing homes, and other medical facilities that accept Medicare and Medicaid to inform patients over 18 years of age of their right to prepare an advance directive or living will that would instruct health care providers to remove life-sustaining equipment if the patient becomes terminally ill. Although physicians are not subject to the provisions of the law, it is important that they understand the nature of advance directives. To assist physicians, Med Chi developed a brochure for providers to give to their patients. A copy of the brochure and a summary of the new law was mailed to all Med Chi members.

"Safe harbor" regulations

In the July 29, 1991 issue of the *Federal Register*, the Department of Health and Human Services (DHHS) published "safe harbor" regulations intended to define business arrangements and payment practices for physicians participating in Medicare and Medicaid.

To help physicians comply with the new law, Med Chi featured an article on the new regulations in the fall 1991 issue of the *Physician's Practice Digest*.

Health care reform

In 1991-1992, health care reform was also the focus of national attention. As a result, a number of health care reform proposals were introduced at the state level during the 1992 General Assembly. Among them was HB

667, which would create a single-payer health care system, similar to the Canadian health system. Other proposals included HB 375, which would require employers to provide health care insurance, and HB 376, which would provide tax credits and vouchers for employees to use to purchase health insurance. Although none of these legislative proposals passed this session, Med Chi anticipates that health care reform will be an increasingly significant issue.

"Health Access America"

Throughout 1991-1992, Med Chi continued its support of "Health Access America," the AMA's proposal to ensure access to affordable, quality health care for all Americans. In December 1991, Med Chi was able to expand its outreach efforts in Maryland because of two grants from the AMA. Under the first grant, Med Chi worked in conjunction with the National Black Health Study Group to promote "Health Access America" to the African-American population. Under the second grant, Med Chi expanded its ongoing outreach efforts to include not only physicians but also community groups, the media, and legislators. In addition to sending physician speakers to several community groups throughout the state, Med Chi sponsored a special "Health Access America" night at Oriole Park at Camden Yards. As part of the event, Med Chi made arrangements to have the message, "Health Access America...MDs Care," displayed on the score board at the stadium.

President's regional conferences

Because increased communication with physicians was a major focus during 1991-1992, Med Chi continued to sponsor president's regional conferences in southern, western, and eastern Maryland. Med Chi expanded upon the conferences this year by surveying conference participants and offering continuing medical education credits at the meetings. The surveys allowed Med Chi to prepare presentations on issues of local interest in advance and to determine the nature of the continuing medical education program.

Annual meeting

Continuing medical education programs were the core of Med Chi's 1992 Annual Meeting on April 30-May 2, 1992 at the Omni Inner Harbor Hotel. AMA Trustee Thomas Rardon, M.D. was featured speaker at the meeting and spoke during the plenary session on health care reform with DHHS Deputy Secretary Kevin E. Moley. Physicians attending the meeting had the opportunity to earn continuing medical education credits at the more than twenty scientific sessions.

Semiannual meeting

Med Chi's 1991 Semiannual Meeting was held September 13-15, 1991 at the Carousel Hotel in Ocean City. Highlights of the meeting included the sessions on

- Medicare physician payment update
- Mammography standards and x-ray assistant classification
- *Practice Protocol for Physicians with HIV*

The sessions on mammography standards and on physicians with HIV proved very successful because they allowed members to voice their opinions on issues that would later become Med Chi policy. As a result of these discussions, the House of Delegates was kept informed about issues facing the profession of medicine.

Also during the House of Delegates meeting, AMA Trustee Robert McAfee presented the keynote address on "Medical Practice Parameters and Challenges to Medicine in the 1990s."

Physician rehabilitation

In addition to the annual and semiannual meetings, Med Chi began expanding its educational efforts by sponsoring two other continuing medical education programs for its physicians in 1991-1992. In November 1991, over 100 physicians attended the second annual conference on "Addiction and Physician Health" sponsored by the Physician's Rehabilitation Committee and the Committee on Alcoholism and Chemical Dependency. The conference, which was designed to help physicians recognize and treat patients impaired by drugs or alcohol,

addressed topics such as chemical dependency, alcoholism, sexual exploitation of patients, physician impairment, and the HIV-positive physician.

Performing arts medicine

In January 1991, more than fifty health care practitioners attended Med Chi's Committee on Medicine and the Performing Arts conference, "Performing Arts Medicine: Issues in Diagnosis and Management." Topics during this conference addressed the special medical needs of performing artists.

Special events

There were several events of the 1991-1992 year that are of historical significance. The first occurred in June 1991 when Henry N. Wagner, Jr., M.D. received the AMA's scientific achievement award for his outstanding research in nuclear medicine. The second happened on October 15, 1991 when a delegation of physicians from the Kanagawa Prefecture in Japan visited Med Chi to exchange medical information. During their visit, Kanagawa Prefecture Medical Association President Ryohei Kawguchi, M.D. and Med Chi President J. David Nagel, M.D. signed an agreement for cooperation, friendship, and exchange between Med Chi and the Kanagawa Prefecture Medical Association. The third historical event occurred in December 1991 when Med Chi was honored again when the AMA presented George S. Malouf, Sr., M.D. with the Benjamin Rush Award for Citizenship and Community Service in recognition of his exceptional service to the people of Maryland and Prince George's County. The fourth event took place in June 1992 at the AMA annual meeting when Med Chi Past President Donald T. Lewers, M.D. announced his plans to run for the AMA Board of Trustees in 1993.

On behalf of all the staff, I would like to thank Med Chi's membership for their assistance during 1991-1992. Your contributions have helped to make a successful year.

Angelo J. Troisi, F.A.C.I.E., executive director

The Maryland Medical Political Action Committee

Mr. President and Members of the House of Delegates:

Since 1991 was not an election year, the Maryland Medical Political Action Committee (MMPAC) was able to conserve much of its financial resources for use in 1992. Contributions to political fund raisers were minimal, but expenditures were made for educational purposes. The annual physicians' visit to Annapolis was a success. Many doctors attended the rally, heard messages from important speakers, and then met with individual legislators to discuss issues.

The MMPAC bylaws were amended by the board. The bylaws are now clearer and will enable the board to operate more efficiently.

At the annual meeting, the American Medical Political Action Committee (AMPAC) presented an award to MMPAC for the substantial increase in membership in 1991. Dr. Lynn accepted the award and then addressed the House of Delegates.

In 1992, MMPAC will have the opportunity to influence the disposition of many political issues important to physicians and the practice of medicine. MMPAC needs the support of every doctor in Maryland. Please join those who already are involved with their money and talents.

John T. Lynn, M.D., chairperson

Jeffrey A. Abend, M.D.

Brian S. Bayly, M.D.

Marianne Benkert, M.D.

Bessie Blair

Albert L. Blumberg, M.D.

Harold B. Bob, M.D.

John W. Clark, M.D.

Josie Figueroa

Elie K. Fraiji, M.D.

Joseph J. Harrison, C.P.A.

Frederick J. Hatem, M.D.

Bernard S. Kleiman, M.D.

Henry P. Laughlin, M.D., Sc.D., Sc.S.D.

Donald T. Lewers, M.D.

Mayer C. Liebman, M.D.

Vivian Lynn

George S. Malouf, Sr., M.D.

J. David Nagel, M.D.

Hiroshi Nakazawa, M.D.

Susan W. Owens, M.D.

Gary L. Rosenberg, M.D.

Marvin Schneider, M.D.

Sue Sherwood

Roland T. Smoot, M.D.

Catherine N. Smoot-Haselhus, M.D.

Angelo J. Troisi, F.A.C.H.E.

Lawrence R. Whicker, Jr., M.D.

Jose M. Yosunico, M.D.

Med Chi Insurance Fund

Mr. President and Members of the House of Delegates:

The Med Chi Insurance Fund Board of Directors met six times in 1991 and conferred by several telephone conferences in carrying out its responsibilities for the Insurance Fund and the Med Chi Agency (the Agency). The bylaws of the Insurance Fund and the bylaws and articles of incorporation of the Med Chi Agency were reviewed by an attorney to bring them up-to-date and in compliance with any new laws or requirements. Appropriate amendments were approved by the board.

A new individual disability policy of the Paul Revere Insurance Company is now offered through the Agency. This policy contains the best provisions, policy language, and benefits available to the medical profession. Med Chi members are eligible for a discount of up to 25 percent. The Paul Revere Insurance Company ranked number one among all companies in 1989 and 1990 for total disability premiums in force. It is ranked A+ (superior) by AM Best and AA- (excellent) by Standard and Poor.

The board approved a new Blue Cross/Blue Shield plan option effective September 1, 1991 in its efforts to keep health health insurance down. It is a comprehensive plan with a \$500 deductible.

After reviewing the financial statements and claim reports with company representatives, the board approved a 10 percent premium increase for the

Hartford major medical plan. This was minimal compared with other similar plans. The group disability plan premiums were not increased.

The Agency has contracted with the Travelers Insurance Company, which offers a variety of small group plans and various coverage options within the plans. Also available are health plans for temporary personnel and students.

The property and casualty business has increased and will continue to grow because of additional staff and more products.

The number of Medical Mutual professional liability policyholders has continued to increase. The volume will grow, but commission income may not because of lower premiums and special discounts from the company.

The Agency had another successful year, and the membership has benefited as a result. The board is very appreciative of the support of the members and will strive diligently to provide high quality, competitively priced products and services.

*Francis C. Mayle, Jr., M.D.,
chairperson*

Raymond M. Atkins, M.D.

Albert M. Antlitz, M.D.

Albert L. Blumberg, M.D.

Michael R. Dobridge, M.D.

George S. Malouf, Sr., M.D.

J. David Nagel, M.D.

Treasurer's Report

Mr. President and Members of the House of Delegates:

The financial books and records of the Faculty for the year ending December 31, 1991 have been audited by the firm of Naden Lean, Certified Public Accountants.

The financial statements reflecting the financial position of the Faculty at year end 1990 and 1991 and the related

statements of income, expenditures, transfers, and changes in fund balances for the years then ended are published in this *Maryland Medical Journal*. The auditors submitted an unqualified opinion that the financial statements are accurate and conform to generally accepted accounting principles.

The 1991 budget was approved by the Council in November 1991 and is presented in this *Maryland Medical Journal* for information purposes.

Albert L. Blumberg, M.D., treasurer

Naden/Lean

CERTIFIED PUBLIC ACCOUNTANTS AND BUSINESS CONSULTANTS

INDEPENDENT AUDITORS' REPORT

The Medical and Chirurgical Faculty
of Maryland
Baltimore, Maryland

We have audited the accompanying balance sheets of the Medical and Chirurgical Faculty of Maryland as of December 31, 1991 and 1990, and the related statements of income, expenditures and transfers, changes in fund balances, and cash flows for the years then ended. These financial statements are the responsibility of the Faculty's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Medical and Chirurgical Faculty of Maryland at December 31, 1991 and 1990, and the results of its operations, changes in fund balances, and cash flows for the years then ended, in conformity with generally accepted accounting principles.

Our audits were conducted for the purpose of expressing an opinion on the basic financial statements taken as a whole. The supplementary information is presented for purposes of additional analysis and is not a required part of the basic financial statements. Such information has been subjected to the procedures applied in the audits of the basic financial statements and, in our opinion, is fairly stated in relation to the basic financial statement taken as a whole.

Naden Lean
May 13, 1991
Lutherville, Maryland

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Supplemental Reports

THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND BALANCE SHEETS DECEMBER 31, 1991 AND 1990

	General Funds	Med-Chi Insurance Fund	Plant Fund	Restricted Funds		All Funds 1991	Total All Funds Restated 1990 (Note 6)
				Endowment and Special Funds	Other Restricted Funds		
ASSETS							
Current							
Cash	\$3,816,350	\$3,733,115	\$ -	\$ 223,207	\$387,074	\$ 8,159,746	\$ 7,815,541
Accounts Receivable							
Membership dues, journal & advertising	58,957	-	-	-	51,425	110,382	97,030
Other Funds	36,029	-	-	702,077	-	702,077	742,699
The Med-Chi Agency, Inc.	15,901	20,089	-	19,165	-	75,283	170,518
Loans receivable	-	-	-	-	-	15,901	225,302
Prepaid pension cost	170,475	-	-	-	-	-	81,875
Prepaid expenses	22,333	-	-	-	-	170,475	97,057
TOTAL CURRENT ASSETS	4,120,045	3,753,204	-	944,449	438,499	22,333	19,216
Marketable securities				2,186,614		9,256,197	9,249,238
Investment - The Med-Chi Agency, Inc.	113,493	-	-	-	-	2,186,614	2,144,579
Investment-Management Services Corp of Med-Chi, Inc.	12,772	-	-	-	-	113,493	93,304
Fixed Assets - Net	-	-	2,830,819	-	-	12,772	11,629
TOTAL ASSETS	\$4,246,310	\$3,753,204	\$2,830,819	\$3,131,063	\$511,476	\$14,472,872	\$14,482,886
LIABILITIES AND FUND BALANCES							
Current							
Accounts Payable							
Trade	\$ 48,529	\$2,683,421	\$ -	\$ -	\$ 4,000	\$ 2,735,950	\$ 2,595,453
Other funds	73,227	449,507	-	-	179,343	702,077	742,699
The Med-Chi Agency, Inc.	-	96,898	-	-	-	96,898	74,868
Component societies	793,633	-	-	-	-	793,633	711,625
Payroll taxes	10,000	-	-	-	-	10,000	9,580
Accrued expenses	89,883	-	-	-	-	89,883	80,196
Deferred income	877,187	-	-	-	1,500	878,687	797,955
Deferred compensation	54,157	-	-	166,785	-	220,942	259,062
TOTAL CURRENT LIABILITIES	1,946,616	3,229,826	-	166,785	184,843	5,528,070	5,271,438
Fund Balances							
Investment in fixed assets	-	-	2,830,819	-	-	2,830,819	2,930,782
Designated Funds							
Legal fund	87,425	-	-	-	-	87,425	87,425
Educational purpose	86,063	-	-	-	-	86,063	76,199
Continuing medical education	19,970	-	-	-	-	19,970	16,386
Building fund	81,271	-	-	-	-	81,271	71,202
Coggins building fund	17,425	-	-	-	-	17,425	23,583
Membership services reserve	196,417	-	-	-	-	196,417	174,477
Other	18,116	-	-	-	-	18,116	17,798
Restricted funds	-	-	-	2,964,278	326,633	3,290,911	3,361,470
Unrestricted	1,793,007	523,378	-	-	-	2,316,385	2,452,126
TOTAL FUND BALANCES	2,299,694	523,378	2,830,819	2,964,278	326,633	8,944,802	9,211,448
TOTAL LIABILITIES AND FUND BALANCES	\$4,246,310	\$3,753,204	\$2,830,819	\$3,131,063	\$511,476	\$14,472,872	\$14,482,886

See independent auditors' report and accompanying notes.

THE MEDICAL AND CHIRURGICAL FACULTY
OF MARYLAND
STATEMENTS OF REVENUE AND EXPENSES
YEARS ENDED DECEMBER 31, 1991 and 1992

See independent auditors' report and accompanying notes.

THE MEDICAL AND CHIRURGICAL FACULTY
OF MARYLAND
STATEMENTS OF CHANGES IN FUND BALANCES
YEARS ENDED DECEMBER 31 1991 and 1990

	General Funds Designated	General Funds Undesignated	Med-Chi Insurance Fund	Plant Fund	Restricted Funds			Total All Funds
					Endowment and Special Funds	Physician's Rehab. Fund	Other Funds	
Fund Balances, December 31, 1989 as previously reported	\$315,694	\$1,915,611	\$535,060	\$3,910,774	\$2,867,522	\$ -	\$ -	\$9,544,661
Fund transfers		(55,652)		55,652				-
Prior period adjustments (Note 6):								
Recordation of compensated absences	-	(66,332)	-	-	-	-	-	(66,332)
Pension expense adjustment	-	83,878	-	-	-	-	-	83,878
Depreciation expense adjustment	-	-	-	(952,526)	-	-	-	(952,526)
Fund Balances, December 31, 1989, as restated	315,694	1,877,505	535,060	3,013,900	2,867,522	-	-	8,609,681
(DEFICIENCY) EXCESS OF REVENUE AND GRANTS OVER EXPENSES, GAIN (LOSS) ON SALE OF SECURITIES AND WRITE- DOWN OF LOANS RECEIVABLE, AS RESTATED (NOTE 6)	151,376	(272,598)	354,107	(125,066)	(9,746)	-	503,694	601,767
Fund Transfers:								
Med-Chi insurance to general fund	-	340,000	(340,000)	-	-	-	-	-
General to plant fund	-	(41,948)	-	41,948	-	-	-	-
	-	298,052	(340,000)	41,948	-	-	-	-
Fund Balances, December 31, 1990	467,070	1,902,959	549,167	2,930,782	2,857,776	-	503,694	9,211,448
(DEFICIENCY) EXCESS OF REVENUE AND GRANTS OVER EXPENSES, GAIN (LOSS) ON SALE OF SECURITIES AND WRITE-DOWN OF LOANS RECEIVABLE	39,617	(378,389)	259,211	(114,074)	106,502	(177,061)	(2,452)	(266,646)
Fund Transfers:								
Med-Chi insurance to general fund	-	285,000	(285,000)	-	-	-	-	-
General to restricted fund	-	(2,452)	-	-	-	-	2,452	-
General to plant fund	-	(14,111)	-	14,111	-	-	-	-
	-	268,437	(285,000)	14,111	-	-	2,452	-
FUND BALANCES, DECEMBER 31, 1991	\$506,687	\$1,793,007	\$523,378	\$2,830,819	\$2,964,278	\$ (177,061)	\$503,694	\$8,944,802

See independent auditors' report and accompanying notes.

Notes To Financial Statements

December 31, 1991

Note 1. Summary of significant accounting policies*Entity*

The Medical and Chirurgical Faculty of Maryland (the Faculty) is a nonprofit organization, tax exempt under section 501(c)(6) of the Internal Revenue Code.

Fund accounting

The accounts of the Faculty are maintained in accordance with the principles of fund accounting whereby resources are classified for accounting and reporting purposes into funds established according to their nature and purpose. Separate accounts are maintained for each fund; accordingly, the assets, liabilities, and fund balances are recorded in self-balancing funds as follows:

- General funds used to account for revenues and expenses related to the operation and management of the Faculty's general operations. Certain board designated amounts are also reflected in this fund.
- Endowment and special funds used to account for resources which are available for use, but expendable only for the purposes specifically designated by the donor.
- Plant fund used to account for the Faculty's investment in fixed assets.
- Med Chi insurance fund used to record billing and disbursement transactions related to the administration of insurance activities.
- Restricted funds used to account for revenues and expenses related to the Physician Rehabilitation, Baltimore Substance Abuse, March of Dimes, and AMA-"Health Access America" grant programs.

Description of major programs supported through restricted funds

- **Physician Rehabilitation Program.** The goal of this program is to identify physicians unable to

practice medicine with reasonable skill and safety due to physical or mental illness, including alcoholism or drug dependence, and to provide assistance to the physician in obtaining rehabilitation, either through private or public sources.

The Physician Rehabilitation Program is available to all physicians in the state of Maryland, their family members, and medical students.

- **Baltimore Substance Abuse Program.** This program was established to develop a curriculum for primary care physicians on how to screen, counsel, and refer their substance abusing patients. This curriculum will be presented to local hospitals, community health centers, and the like. The goal of this program is to provide this information to all primary care physicians in Baltimore City.
- **March of Dimes Program.** The purpose of this program is to conduct a continuing medical education program for practicing physicians that will enable them to help their pregnant patients stop smoking. Presentations were held at area hospitals.
- **AMA's "Health Access America" Program.** This program supports Med Chi's outreach efforts to inform Maryland physicians of a proposal developed by the American Medical Association to improve access to affordable, quality health care in the United States. This proposal is designed to control health care cost increases, reform Medicare and Medicaid, and insure that all Americans have access to health care.

Fixed assets

Fixed assets are stated at cost or, if donated, at the approximate fair value at the date of donation. Depreciation is computed for fixed assets acquired prior to 1981 using the straight line method over the estimated useful lives of related assets. For assets acquired

subsequent to 1980, depreciation is computed using the accelerated cost recovery or modified accelerated cost recovery systems based on the estimated useful lives of the related assets.

Depreciation expense for the years ended December 31, 1991 and 1990 was \$137,062 and \$136,802, respectively.

Marketable securities

Marketable securities are carried at cost. Market values at December 31, 1991 and 1990 were \$2,870,658 and \$2,502,705, respectively.

Investment in subsidiaries

The Faculty carries its investment in the 100 percent-owned Med Chi Agency, Inc. (the Agency) as equity. The net assets of the Agency as of December 31, 1991 and 1990 were as follows:

	1991	1990
Current assets	\$158,836	\$431,112
Fixed assets—net	22,130	14,626
	<u>\$180,966</u>	<u>\$445,738</u>
Current liabilities	61,335	352,434
	<u>\$119,631</u>	<u>\$93,304</u>

The Agency generated net income for the years ended December 31, 1991 and 1990 of \$326,327 and \$319,514, respectively.

The Faculty carries its investment in the 100 percent-owned Management Services Corporation of Med Chi, Inc. (the Corporation) at equity. The net assets of the Corporation as of December 31, 1991 and 1990 were \$12,772 and \$11,629, respectively.

Deferred income

Deferred income reflects dues and fees collected in November and December for the subsequent year.

Financial statement presentation

Certain amounts in 1990 have been reclassified to conform with 1991 presentation. In addition, certain amounts in 1990 have been restated as discussed in Note 6.

Supplemental Reports

Note 2. Fixed assets

Fixed assets at December 31, 1991 and 1990 are summarized as follows:

	1991	1990	Life in Years
PLANT FUND			
Land, building, and improvements			
<i>1209-1215 Cathedral Street</i>			
Land and building	\$ 110,636	\$ 110,636	40
Improvements	543,035	543,035	40
<i>1205-1207 Cathedral Street</i>			
<i>and 1204 Maryland Avenue</i>			
Land and buildings	2,138,624	2,138,624	40
Improvements	188,296	188,296	40
<i>224 Main Street, Annapolis</i>			
Land and buildings	545,856	545,856	40
Total cost	3,526,447	3,526,447	40
Less accumulated depreciation	(748,063)	(662,668)	
	<u>2,778,384</u>	<u>2,863,779</u>	
Other			
Library books, journals	231,370	231,370	10
Office and library fixtures, antiques, and museum pieces	87,570	87,570	10
Portraits	65,000	65,000	10
Office furniture and equipment	364,861	350,750	5-7
Automobiles	15,700	15,700	3
Total cost	764,501	750,390	
Less accumulated depreciation	(712,066)	(683,387)	
	52,435	67,003	
Total plant fund—net	<u>2,830,819</u>	<u>2,930,782</u>	
	December	December	Life in
	1991	1990	Years
RESTRICTED FUNDS			
Office renovations	\$ 22,995	\$ ----	31.5
Less accumulated depreciation	(639)	----	
	<u>22,356</u>	<u>----</u>	
Office equipment and furniture	84,674	58,519	5-7
Construction in progress, office renovations	----	6,539	
Total cost	84,674	65,058	
Less accumulated depreciation	(34,053)	(11,704)	
	50,621	53,354	
Total restricted funds—net	<u>72,977</u>	<u>53,354</u>	
TOTAL FIXED ASSETS—NET	<u>\$2,903,796</u>	<u>\$2,984,136</u>	

Note 3. Write-down of loans receivable

At 12/31/91, the Faculty wrote-off \$172,835 of loans receivable from Healthcare Credentials Verification, Inc. The receivables were considered uncollectible since they were unsecured and due to the cessation of Healthcare Credentials Verification, Inc.'s operations. Additionally, the Faculty wrote-off \$53,204 of loans receivable from Maryland Foundation for Health Care which were not considered collectible due to financial difficulties experienced by the company.

Note 4. Pension plan

The Faculty sponsors a noncontributory defined benefit pension plan (the Plan) that covers substantially all employees of the Faculty and its subsidiaries who have attained the age of 21 and completed one year of service. The Plan calls for benefits to be paid to eligible employees at retirement based on the average compensation for the five highest consecutive years of credited service. The Faculty's funding policy is to fund pension costs accrued. Actuarially determined pension costs are funded on an annual basis by the Frozen Initial Liability Method with initial accrued liabilities compensated under the Entry Age Normal Tax Method. Effective January 1, 1990, the Faculty adopted FASB Statement No. 87, *Employers' Accounting for Pensions*, for the Plan. The effects of this change are discussed in Note 6.

Plan assets consist primarily of common and preferred stocks, corporate bonds, mutual funds, and short-term investments.

The following table set forth the plan's funded status and amounts recognized in the Faculty's balance sheets at December 31:

Supplemental Reports

	1991	Restated 1990 (Note 6)
ACTUARIAL PRESENT VALUE OF BENEFIT OBLIGATIONS		
Accumulated benefit obligation		
Vested	\$ 477,504	\$ 482,785
Non-vested	<u>64,035</u>	<u>33,979</u>
	541,539	516,964
Effect of anticipated future compensation levels and other events	<u>257,571</u>	<u>245,590</u>
Projected benefit obligation for service rendered to date	799,110	762,554
Plan assets at fair value	<u>1,307,304</u>	<u>1,204,197</u>
Plan assets in excess of projected benefit obligation	508,194	261,643
Unrecognized net (gain) loss	(30,054)	155,105
Unrecognized net transition asset (from adoption of FASB Statement No. 87)	<u>(307,665)</u>	<u>(319,691)</u>
Prepaid pension cost recognized on balance sheet	<u>\$ 170,475</u>	<u>\$ 97,057</u>

Actuarial pension expense for 1991 and 1990 includes the following components:

	1991	Restated 1990 (Note 6)
Service cost of the current period	\$ 71,035	\$ 74,383
Interest cost on the projected benefit obligation	59,476	65,684
Estimated return on assets held in the plan	(220,470)	(285)
Net amortization and deferral	<u>114,713</u>	<u>(111,844)</u>
Net periodic pension expenses	<u>\$ 24,754</u>	<u>\$ 27,938</u>

Actuarial assumptions used in determining the actuarial present value of the projected benefit obligation were as follows:

	1991	1990
Weighted—average discount rate		
Pre-retirement	8%	8%
Post-retirement	7.5	7.5
Rate of increase in future compensation	4	4
Expected long-term rate of return on assets	9	9

Note 5. Related parties

The Medical and Chirurgical Faculty of Maryland owns the stock of the Med Chi Agency, Inc. The Faculty leases office space to the Agency under a month-to-month lease. Lease payments from the Agency were \$18,336 and \$17,286 for 1991 and 1990, respectively. Additionally, the Faculty performed certain management and accounting services for the Agency; income for these services in 1991 and 1990 was \$121,000 and \$122,000, respectively.

The Medical and Chirurgical Faculty of Maryland owns the stock of Management Services Corporation of Med Chi, Inc. There were no charges to the Corporation in 1991 and 1990 for management and accounting services performed by the Faculty for the Corporation.

Note 6. Prior period adjustments

The Faculty's financial statements as of December 31, 1990 contained items that had the effect of understating the fund balance of the undesignated general fund by \$108,361 and overstating the fund balance of the plant fund by \$1,077,592. The items noted were as follows:

- **Recordation of compensated absences.** No accrual was provided for compensated absences as required by SFAS No. 43, *Accounting for Compensated Absences*.
- **Pension expense adjustment.** Pension expense was not computed in accordance with statement of Financial Accounting Standards (SFAS) No. 87, *Employer's Accounting for Pensions*.
- **Depreciation expense adjustment.** Depreciation was not provided for fixed assets in accordance with SFAS No. 93, *Recognition of Depreciation by Not-for-Profit Organizations*.

The change in the method of recording pension expense resulted in a reduction of pension expense of \$45,246 and \$111,351 for the years ended December 31, 1991 and 1990, respectively.

MEDICAL & CHIRURGICAL FACULTY OF MD

APPROVED 1992 BUDGET

DEPARTMENTAL REVENUE

FINANCE & MEMBERSHIP

Membership Dues	1,173,700
Membership Services Fund	99,441
Investment - Short-term	150,000
Investment - Med-Chi Agency	350,000
Investment - Other Funds	300,000
Insurance Activities	122,000
Rental Income	73,800
Collection Service	30,000
Credit Cards	2,000
Parking	800
MPS Computer Billing	100
Lists & Labels	10,000
Subscription Service	200
Dues Collection Fees	15,000
Specialist Identification	5,000
Adverse Decisions	200
TOTAL	2,332,241

MARYLAND MEDICAL JOURNAL

Local Advertising	136,000
National Advertising	10,000
Classified Ads	7,500
Reprints	2,500
Subscriptions	7,000
Non-Subscription Sales	200
TOTAL	163,200

GRAPHICS

Directory Sales	8,500
Directory Advertising	15,000
Eye Phys. Newsletter	350
MD Psych. Newsletter	600
Phy. Practice Digest	12,000
Design & Artwork - Outside Work	500
Other	5,000
TOTAL	41,950

Supplemental Reports

MEDICAL & CHIRURGICAL FACULTY OF MD

APPROVED 1992 BUDGET

DEPARTMENTAL REVENUE (continued)

PUBLIC RELATIONS & CONVENTIONS

Annual Meeting - Exhibits	50,000
Annual Meeting - Print Ads	7,000
Annual Meeting - Ticket Sales	26,000
Annual Meeting - Registration	500
Workshops	4,000
Semiannual Meeting	13,000
TOTAL	<u>100,500</u>

COMPUTER SERVICES

AMA Profiles	5,000
Malpractice Cases	2,000
TOTAL	<u>7,000</u>

LIBRARY

CPT & ICD9	600
Hospital Library Cataloging	750
Hospital Library Periodicals	300
Interlibrary Loans	12,000
Literature Searches	7,500
Music Medicine	200
Non-affiliated User Registration	3,400
Photocopying	9,000
Physician Book Orders	200
Hospital Book Orders	500
TOTAL	<u>34,450</u>

ASSOCIATION SERVICES

American College of Emergency Phy.	25,000
MD Society of Eye Phy.	20,000
TOTAL	<u>45,000</u>

EDUCATION

Educational Grants	207,468
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CORPORATE/UNDISTRIBUTED

Physician Rehab. Reimbursement	80,000
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TOTAL REVENUES	3,011,809
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TOTAL EXPENSES	3,011,809
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MEDICAL & CHIRURGICAL FACULTY OF MD

APPROVED 1992 BUDGET

EXPENSES BY DEPARTMENT

Expenses	Administra- tion	Finance & Membership	Maintenance & Janitorial	Communica- tions	MMJ	Public Rel. & Conventions	Graphics
Salaries expense	251,787	161,106	86,751	70,196	38,372	27,846	45,900
Benefits expense	69,800	45,110	24,290	19,655	10,744	7,797	12,852
Supplies expense	5,250	6,000	15,000	350	200	2,800	2,000
Equipment expense	4,000	3,000	1,000	3,000			
Equip. maintenance expense	2,500	500	1,000	500		200	700
Software expense							1,200
Travel expense	9,500	1,000	500	600	350	600	300
Education courses expense	1,000	500		300	350	350	300
Membership & certification exp	850	500		150	120	180	
Publications expense	1,000	100		150	100	300	75
Postage & shipping expense	6,000	9,000		300	17,000	8,000	50
Printing & publishing expense	150	3,000			165,000	14,500	
Photocopying expense							
Contract services expense			25,000		8,000	1,400	200
Meetings expense	22,500						
AMA - Delegation travel	55,000						
AMA - OSMAP	300						
AMA - Candidate Support	15,000						
AMA - S.E. Delegation	3,500						
Leadership conf. expense	5,500						
Officers expenses	4,000						
Presidents honorarium	30,000						
Mobile telephone expense	8,000						
Data processing expense		10,000					
Auditing expense		10,000					
Bank Charges expense		300					
Awards expense					200	4,000	
Photo supplies expense							1,800
Gifts & memorials expense						850	
Interlibrary loans expense							
Medlars expense							
Music in medicine							
Legislative health service							
Marketing expense						4,000	
Annual meeting expense						87,420	
Semi-Annual meeting expense						11,500	
Annual report expense						3,000	

Supplemental Reports

Human Resources	Legal & Gov't Relations	Computer Services	Library	Peer Review	Education	Association Services	Corporate	Total
23,450	55,442	69,251	115,733	104,284	171,768	42,840	60,640	1,325,366
6,566	15,524	18,886	32,405	29,200	48,095		16,979	357,903
300	1,000	3,000	3,000	1,700	2,500		6,000	49,100
		5,000	12,000	2,000	2,000		2,000	34,000
50	1,500	5,000	4,000	2,000	500		500	18,950
								1,200
50		1,800	2,500	400	1,900		500	20,000
350	150	500	500	500			200	5,000
300		195	700		200			3,195
200	1,500	750	100	100	200			4,575
500	1,100	1,000	3,500	5,000	2,500		18,000	71,950
			1,000	250	100			184,000
			1,000				40,000	41,000
3,500	360,000	500	3,000					401,600
								22,500
								55,000
								300
								15,000
								3,500
								5,500
								4,000
								30,000
								8,000
								10,000
								10,000
								300
								4,200
								1,800
3,500								4,350
			10,000					10,000
			2,200					2,200
			200					200
	7,400							7,400
								4,000
								87,420
								11,500
								3,000

MEDICAL & CHIRURGICAL FACULTY OF MD

APPROVED 1992 BUDGET

EXPENSES BY DEPARTMENT

Expenses	Administra- tion	Finance & Membership	Maintenance & Janitorial	Communica- tions	MMJ	Public Rel. & Conventions	Graphics
Utilities expense							
Telephone expense							
Telephone-FAX expense							
Annapolis building expense							
Insurance expense							
Auxiliary expense							
Parking expense							
Survey expense							
Handbook expense							2,000
Bylaws expense							2,600
TOTAL	<u>495,637</u>	<u>250,116</u>	<u>153,541</u>	<u>95,201</u>	<u>240,436</u>	<u>174,743</u>	<u>69,977</u>



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Supplemental Reports

Human Resources	Legal & Gov't Relations	Computer Services	Library	Peer Review	Education	Association Services	Corporate	Total
							80,000	80,000
							45,000	45,000
							3,000	3,000
							9,000	9,000
							40,000	40,000
							1,000	1,000
							9,000	9,000
2,200								2,200
								2,000
								2,600
<u>40,966</u>	<u>443,616</u>	<u>105,882</u>	<u>191,838</u>	<u>145,434</u>	<u>229,763</u>	<u>42,840</u>	<u>331,819</u>	<u>3,011,809</u>



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- Other Special Needs



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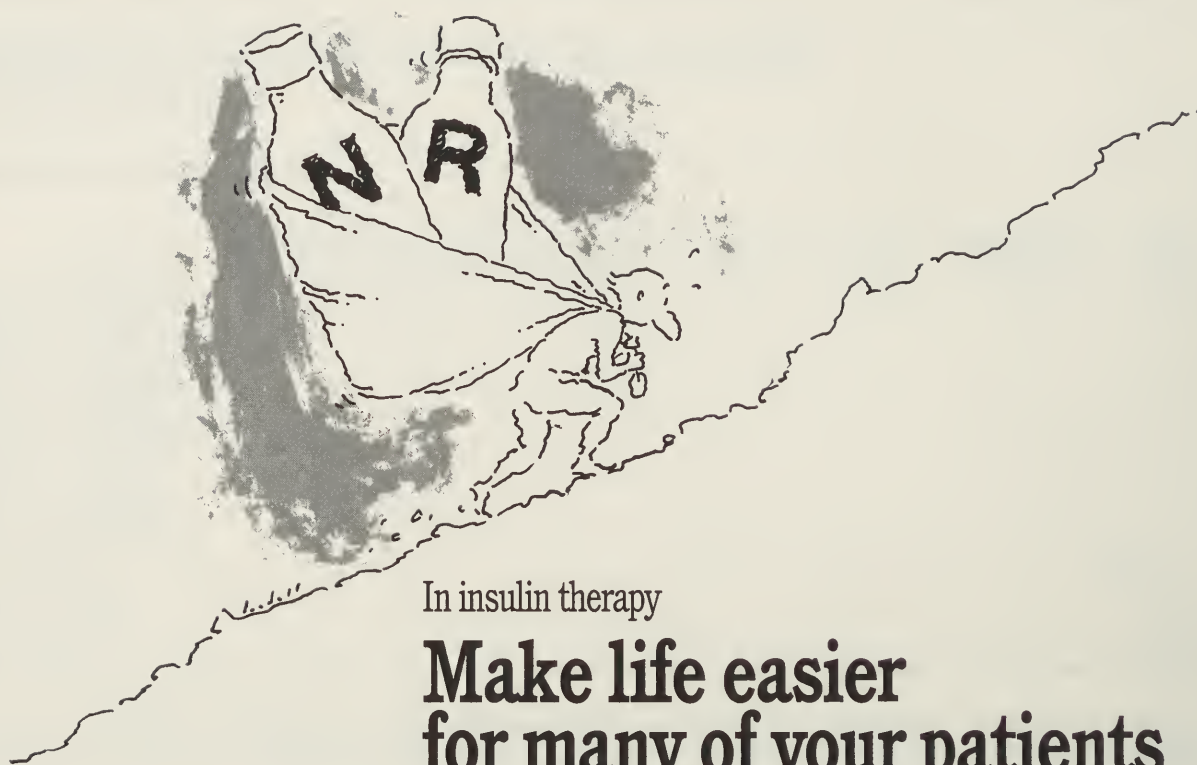
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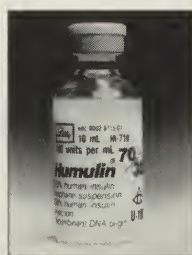
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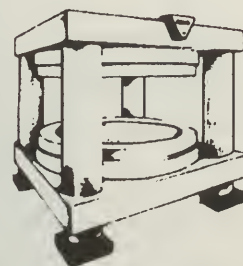
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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon[®] is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

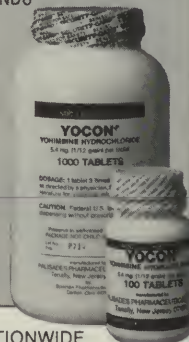
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon[®] 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Med Chi Student Component hosts AMA Medical Student Section Regional Meeting

On Saturday, April 4, 1992, Med Chi's Student Component hosted the annual meeting for the Mid-Atlantic Region of the AMA's Medical Student Section. Students from the following medical schools traveled to Med Chi to attend this regional meeting: University of Maryland, Uniformed Services University of the Health Sciences, Johns Hopkins University, Georgetown University, University of Pittsburgh, Eastern Virginia Medical School, and Robert Wood Johnson Medical School—University of Medicine and Dentistry of New Jersey.

In discussing a theme for the regional meeting, the students focused on the changing face of medicine and chose the title, "The Future of Medicine in the Year 2000." Invited speakers were asked to address issues that were relevant to the future of medicine and medical practice.

The day began with refreshments, registration, and a chance for introductions. Maria Simbra, president of the Mid-Atlantic Region Medical Student Section, opened the meeting and introduced Jeffrey Wise, who is the Student Component's representative to the Faculty's Council. Mr. Wise welcomed the students to Med Chi and Maryland. Robert Ferris, a Student Component member, introduced Michael D. Cantor, J.D., chairperson of the AMA's Medical Student Section Governing Council. Mr. Cantor welcomed the students and provided an overview of the issues facing medical students.

The first speaker on the agenda was Leonard Scherlis, M.D., professor of epidemiology and preventive medicine, University of Maryland School of Medicine. Dr. Scherlis' activities related to health care policy and quality assurance made him an excellent candidate to address legislative issues. His consultant work with the Subcommittee on Health and Long-Term Care, the House Select Committee on Aging, the US House of Representatives, the Health Care Financing Administration, the Health Standards and Quality Bureau, Maryland's Department of Health and Mental Hygiene, and the Governor's Commission on Health Care Policy and Financing, provided him with first-hand knowledge and experience for his presentation, "The Impact of Legislation on Health Care." While Dr.

Scherlis focused on the effects of legislation and regulation upon health care delivery, he further noted that practice guidelines, which are currently used by specialty societies for quality assurance and malpractice protection, may experience general and widespread use in the near future.

The second speaker on the agenda was Colonel Barry W. Wolcott, M.D., commandant, Uniformed Services University for the Health Sciences. Colonel Wolcott's military background in patient care, teaching, and administrative medicine and his experience as a former commander of the Army Medical Actuary at West Point, made him eminently qualified to present "Military Medicine: A Component of America's Future Health Plan." This presentation exposed medical students to the military system of medicine and the various activities surrounding the delivery of health care. Triage, regionalization, and rationing of care were emphasized and presented as a future model for civilian medicine.

After a short break, during which students had the opportunity to question and converse with the speakers, the next program on the agenda targeted public health issues and was aptly titled, "Public Health in the Year 2000." For this timely and important subject, two speakers joined forces in a presentation that addressed current public health care trends. The lead speaker was Jeanette Washington, health planner for the Maryland Health Resources Planning Commission. Ms. Washington has an extensive background in analyzing a statewide primary health care system and in preparing a state health plan section on primary care. Furthermore, her activities related to establishing statewide priorities and goals for improvements in health care personnel supply and services for preventive health, emergency medical care, and end-stage renal disease are published in policy papers and reports. Ms. Washington's portion of the presentation addressed changing demographics including

the aging of the population, the growing minority population, and the shift from acute illness to chronic disease as major health problems. She also introduced the nationwide public health campaign, "Healthy People 2000," a broad-ranging initiative that focuses on



Medical students listen intently to speakers discussing medicine in the year 2000.

public health education and prevention.

Russell W. Moy, M.D., director, Maternal Health and Family Planning, Maryland Department of Health and Mental Hygiene, was the second speaker to address public health issues. Dr. Moy's responsibilities have included overseeing the state's prenatal care services system for over 10,000 health department clients, administering the federal Title V Maternal Health Program in Maryland, overseeing the state's family planning services system for over 70,000 health department clients, administering the federal Title X Family Planning Program in Maryland, and directing projects related to healthy teens and young adults' family planning, the Maryland Norplant Program, and the Maryland State Teen Pregnancy Prevention Program. Dr. Moy's discussion focused on the problem of infant mortality. He noted that although Maryland is one of the wealthiest states, it continues to have a high infant mortality rate. According to Dr. Moy, unusual geography and large inner city representation in the population have been largely responsible for the intractability of infant mortality in Maryland.

The final speaker on the program was Ronald J. Cohen, M.D., chairperson of Med Chi's Peer Review Management Committee. Dr. Cohen's presentation was titled, "Peer Review and Future Considerations." Dr. Cohen's extensive background in peer review has provided him with first-hand knowledge of peer review activities at the state level. Dr. Cohen presented an overview of the peer review system and discussed issues such as practice review, individual incident review, levels of severity concerning allegations, standard of medical care, confidentiality, disciplinary actions, peer review immunity, due process, and physician responsibility.

At the end of Dr. Cohen's session, students were again provided with an opportunity to interact with the speakers and to question them about various aspects of their presentations. The students then gathered in Med Chi's dining room for dinner and a chance to get to know one another.

Following the dinner, a regional AMA Medical Student Section (MSS) business meeting was conducted by Maria Simbra. Ms. Simbra provided information about the annual AMA-MSS meeting (June 1992), which included an educational program on domestic violence. Also discussed were AMA-MSS initiatives related to student loan deferments and pass/fail score reporting for national board examinations.

The day's program ended with a trip to Fells Point and the Inner Harbor hosted by members of Med Chi's Student Component.

SUSAN BOYD, Student Component president
JAMES TRUMBLE, Student Component member
ROSE MATRICCIANI, R.N., J.D., Med Chi's assistant director for Healthcare Policy

Increasing taxes to reduce consumption

Buying a pack of cigarettes now costs twenty cents more thanks to a recent increase in the tobacco excise tax from 16 cents per pack to 36 cents per pack. The tax increase, which went into effect on May 1, 1992, was introduced by Maryland Governor William Donald Schaefer in an effort to reduce cigarette consumption and was supported by Med Chi and several other health organizations throughout the state.

On March 24, 1992, Med Chi members David S. Krimins, M.D. and James D'Orta, M.D., along with Maryland Governor William Donald Schaefer and Department of Health and Mental Hygiene Secretary Nelson J. Sabatini, participated in a press conference to encourage the Maryland General Assembly to pass the new tax. During the conference, the American Lung Association of Maryland arranged for laryngectomy patient Peg Browning and Dr. Krimins to illustrate the hazards of cigarette smoking by using damaged lung and esophageal tissue specimens. Appearing on behalf of the Maryland Thoracic Society, Dr. Krimins' presentation not only helped attendees visualize the dangers of using tobacco but also helped to demonstrate that the Maryland medical community is united against tobacco use.



Maryland Governor William Donald Schaefer holds a model of damaged lung tissue during a press conference to support the 20 cent increase in the cigarette excise tax. Other participants in the conference included (l to r) Peg Browning; David S. Krimins, M.D.; James D'Orta, M.D.; Shelley Buckingham; and Department of Health and Mental Hygiene Secretary Nelson Sabatini.

MEDICAL MISCELLANY

Med Chi's Women in Medicine Committee will hold a brunch for Women in Medicine Month

This month, Med Chi joins the American Medical Association in celebrating September as Women in Medicine Month. The number of female physicians has nearly quadrupled over the past twenty years and is projected to increase to almost 30 percent of the physician population by the year 2010. However, female physicians' membership and participation levels in organized medicine remain disproportionately lower than for their male colleagues.

What makes women's perspectives different and valuable? According to a 1990 Harvard study, female physicians have to balance family and professional responsibilities in ways that men do not. Women physicians generally assume many basic life responsibilities. In this country, women are still responsible for assuring that the family is fed, household finances are managed, housework is done, and children are cared for and educated. These experiences help women develop a practical viewpoint, one grounded in the realities of life. As a result, many women turn to medicine as a natural extension of caring, expanding their horizon from immediate family to the family of humankind, and tend toward "home issues" such as prevention, public health, and sanitation, as well as pediatric, obstetric, and gynecologic cases.

It is for the purpose of having a casual open discussion about the issues faced by women in medicine that the Women in Medicine Committee is holding a brunch on Sunday, September 27, 1992 at the Towson Sheraton. All women physicians and their spouses are encouraged to attend this event. Physicians will be responsible for the cost of the brunch. For reservations or for more information, contact Vivian Smith at 410-539-0872 or 1-800-492-1056. ■

A Salute To Women In Medicine



(Seated, then left to right) **Mary Ann Contogiannis, MD**, resident physician member, AMA Board of Trustees (since 1989), surgical resident, East Carolina University School of Medicine, Greenville, NC; **Palma E. Formica, MD**, member, AMA Board of Trustees (since 1990), family physician and chair, Department of Family Practice, St. Peter's Medical Center, New Brunswick, NJ; **Melissa J. Garretson**, medical student member, AMA Board of Trustees (beginning June 1992), medical student, Mayo Medical School, Rochester, MN; **Nancy W. Dickey, MD**, member, AMA Board of Trustees (since 1989), family physician, Fort Bend Family Health Center, Richmond, TX.

From AMA Services, Inc.

During Women in Medicine Month, celebrated this September, all women who have achieved prominence in organized medicine are honored.

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William Donald Schaefer - Governor of Maryland



EPIDEMIOLOGY & DISEASE CONTROL PROGRAM

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Nelson J. Sabatini - Secretary
Department of Health & Mental Hygiene

J. Mehnen Joseph, PhD - Director
Community Health Surveillance & Laboratories Admin.

Ebenezer Israel, MD, MPH - Director
Epidemiology & Disease Control Program

September, 1992

SELECTED COMMUNICABLE DISEASES IN MARYLAND IN 1991 (Continued)

HAEMOPHILUS INFLUENZAE DISEASE (40)

0.8/100,000 (U.S. 1.0/100,000)

The trend of *H. influenzae* disease in the past 5 years is shown in Figure 3. Cases declined 28 percent from 1990 to 1991 (57 to 40 cases, respectively), continuing the decline which began in 1989. Table 1 (see July, 1992 issue) shows the number of cases by jurisdiction. Almost one third of the cases were reported from Baltimore City (13 cases; 1.7/100,000), but among the jurisdictions with populations above 100,000, Frederick County had the highest rate (5 cases; 3.2/100,000). The disease was more prevalent in the winter months: 22 cases (55%) occurred in January, February, March, and December (peak month with 10 cases).

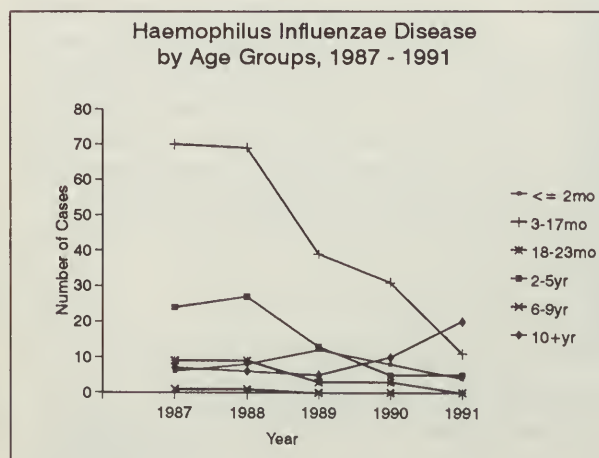


Figure 3

An equal number of males and females were affected. The ratio of whites to blacks was 2.4:1.0; the race of three patients was unknown. The risk for *H. influenzae* disease was greatest among infants less than a year old, including two newborns; the age-specific incidence rate for 100,000 population of this age group was 21.3, followed by the rate in age group 70 to 79 years (2.0/100,000) and 1 to 4 years (2.0/100,000). Figure 3 presents the number of cases by age group from 1987 to 1991.

Active surveillance through hospital infection control practitioners and laboratories for invasive *H. influenzae* disease began in November, 1991. In November and December the number of reported cases in adults rose sharply.

H. influenzae caused the following types of illness: 14 (35.0%) meningitis, 15 (37.5%) bacteremia, 4 (10.0%) pneumonia; 3 (7.5%) epiglottitis, 1 (2.5%) bronchitis, 1 peritonitis, 1 pharyngitis, and 1 conjunctivitis. Four patients died (for a case fatality rate of 13.3%), 30 survived, and the outcome for 6 cases is unknown.

Information on ampicillin resistance of *H. influenzae* isolates from 30 patients showed that 31.8% were resistant to ampicillin, a drop from 57.0% in 1990, and 33.8% in 1985.

HEPATITIS A (258)

5.4/100,000 (U.S. 9.1/100,000)

Hepatitis A has been steadily declining since the outbreak in the metropolitan Baltimore area (Baltimore City, Baltimore County and Anne Arundel County) peaked in 1989. Cases in 1991 declined 79 percent from 1989 when 1200 cases occurred (Figure 4). The number of cases by jurisdiction is shown in Table 1 (see July, 1992 issue). The Baltimore metropolitan area contributed 60.0% of all cases in the State. The highest rate (12.6/100,000) was ob-

served in Baltimore City (93 cases). An additional 63 cases (24.4%) were reported from Montgomery and Prince George's counties. January was the peak month of onset of hepatitis A with 18.8% of the cases. June and October had the fewest cases, (9 during each month).

The male to female ratio was 2.1:1.0. The ratio

Of the 131 adults with known occupation (excluding retired, unemployed, homemakers, etc.), 6 (4.6%) were foodhandlers and 6 were health care providers. Of the 134 cases with known workplace, school, child day care facility, etc., 8 (6.0%) were working in foodhandling businesses, 7 (5.2%) worked in hospitals or institutions for the disabled, and 6 (4.5%) in nursing homes. A known or suspected source of infection was reported for only 91 (35.3%) of the cases. Of these, 33 (36.3%) had contact with a confirmed or suspected hepatitis A case, 20 (22.0%) were refugees/immigrants from developing countries, 19 (20.9%) had handled and/or consumed potentially contaminated food or water, including 8 cases who had consumed shell fish, 11 (12.1%) used illegal drugs (compared to 17.9% in 1990 and 22.7% in 1989), 3 (3.3%) had contact with child or employee in nursery or a day care center, and 5 (5.5%) had other exposures.

HEPATITIS B (387)

8.1/100,000 (U.S. 6.7/100,000)

The trend of hepatitis B in Maryland in the past 12 years is reflected in Figure 4. The decline noted first in 1987 has continued through 1991. The number of cases by county is shown in Table 1 (see July, 1992 issue). Baltimore City reported 34.6 percent of all cases in the State, for a rate of 18.1 per 100,000 population, which represents a decrease from the rate in 1990 (26.1) and 1989 (39.5).

A slight preponderance of illness in the winter months was observed: 42.2% of the cases occurred in January through April. The male to female ratio was 1.4:1.0. The incidence rate in males was 9.7/100,000; in females 6.5/100,000.

The rates per 100,000 population by age group and sex are presented in Figure 6. The highest incidence rates were observed in males, 25 to 29 years of age (22.6), and in females, 20 to 24 years of age (19.5). The ratio of whites to non-whites was 1.1:1.0; the race of 39 cases was not known.

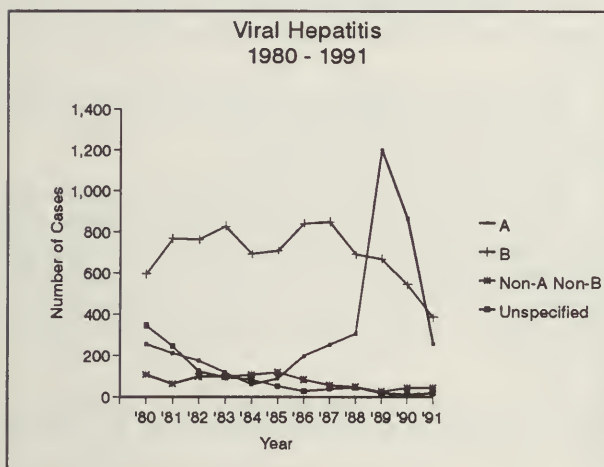


Figure 4

of whites to blacks was 2.8:1.0; 7 cases were Hispanic, 3 Asian, 4 other race, and the race of 40 (15.5%) was not specified. Age- and sex-specific rates per 100,000 are presented in Figure 5. The highest incidence rates occurred in males 25 to 29 and 30 to 39 years of age (14.1 and 13.3) respectively). The highest rate (5.7) among females was noted in age group 20 to 24 years.

Among the cases with known sex and race (218), the highest rate was observed in non-white males (6.9) followed by white males (6.0), non-white females (3.2.) and white females (2.9).

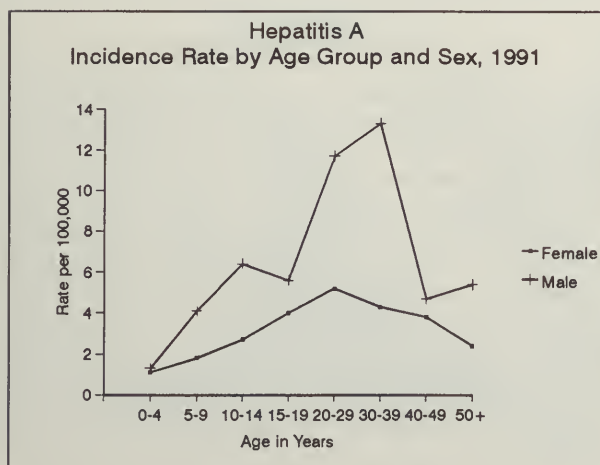


Figure 5

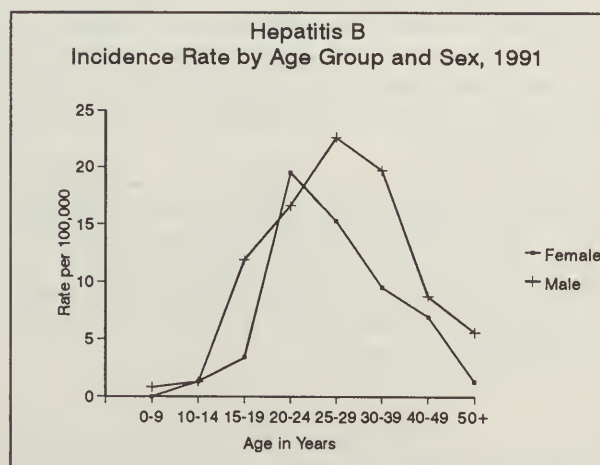


Figure 6

The incidence rates per 100,000 population in non-whites (12.6) was 2.5 times higher than the rate in whites (5.0). The highest rate was observed in non-white males (14.2), followed by non-white females (11.2), white males (6.3), and white females (3.9).

Of the 151 adults with known occupation (excluding retired, unemployed, homemakers, etc.), 10 (6.6%) were health care providers and 2 additional cases were known to have been employed in a hospital. Information on exposure during the 6 months prior to onset of illness and the probable source of infection was available for only 115 (29.7%) cases. Of these, 38 (33.0%) admitted drug use (compared to 31.0% in 1990 and 46.5% in 1989), 28 (24.3%) had heterosexual and unspecified sexual exposure, 21 (18.3%) had contact with a confirmed or suspected hepatitis B case, 8 (7.0%) had blood transfusion, 4 (3.5%) had dental work, 3 (2.6%) were recent refugees, 2 (1.7%) were employed in a medical field, 2 (1.7%) had homosexual exposure, 2 (1.7%) had been hospitalized for illnesses unrelated to hepatitis B, 2 (1.7%) had had a tattoo, 1 (0.9%) was a patient in dialysis unit, 1 (0.9%) had acupuncture, 1 (0.9%) had a needle stick, 1 had other percutaneous exposure (other than I.V. drug use, tattoo, or needle stick), and 1 had travelled abroad.

HEPATITIS NON A - NON B (45)

0.9/100,000 (U.S. 1.2/100,000)

The trend of non A-non B hepatitis from 1980 to 1991 is illustrated in Figure 4. The incidence rate in 1991 did not change from the rate in 1990. The number of cases by jurisdiction is shown in Table 1 (see July, 1992 issue). More than half of the cases (55.6%) occurred in the metropolitan Baltimore area (Baltimore City, Baltimore County, and Anne Arundel County). The highest incidence rate (1.3/100,000) was noted in Wicomico County, a decrease from 6.7/100,000 in 1990). Fifty-one percent of the cases (23) had onset of illness in February through May.

The male to female ratio was 1.4:1.0. The ratio of whites to blacks was 5.0:1.0; one patient was Asian and the race of 2 was unknown. There were no cases less than 15 years of age. White males, 30 to 39 years of age, had the highest incidence rate (2.7/100,000).

The suspected source of infection during the 6 months prior to the onset of illness was reported for 23 cases (51.1%): 12 (52.2%) were illegal drug users, compared to 50.0% in 1990, 8 (34.8%) had received blood or blood products by transfusion, 2 (8.7%) had been exposed to a non A-non B case, and 1 had other exposure.

LEGIONELLOSIS (34)

0.7/100,000 (U.S. 0.5/100,000)

Legionellosis was reported from 14 jurisdictions. The number of cases by jurisdiction is shown in Table 2 (see July, 1992 issue). There was no seasonal trend. The incidence rate in Washington County (4.1/100,000) fell more than 3 times from the rate in 1990 (13.2/100,000) when an outbreak occurred, but still remained one of the highest in the State.

The male to female ratio was 1.3:1.0. The ratio of whites to non-whites was 5.2:1.0; the race of 3 cases was unknown.

Ages ranged from 19 to 85 years (mean 54, median 52 years); the age of 1 person was unknown. The highest incidence occurred among females 80 and over years of age (3.5/100,000) followed by the incidence in males 60 to 69 years of age (2.9/100,000). The incidence by age group is shown in Figure 7.

Information on possible source of exposure and/or underlying medical conditions at the time of

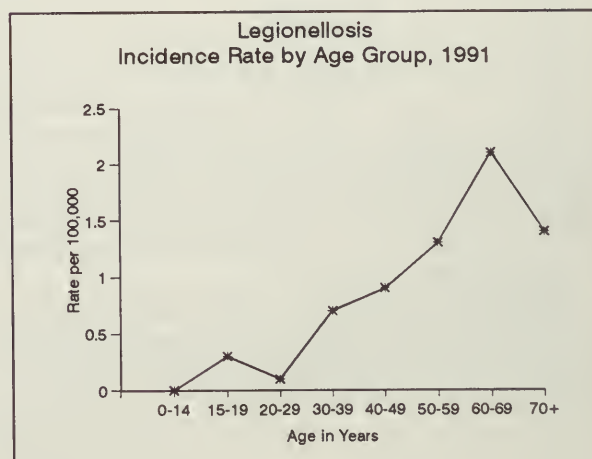


Figure 7

onset of legionellosis was available for 27 (79.4%) cases: 7 were smokers of more than 10 cigarettes/day (including 2 who recently had quit smoking), 3 were undergoing systemic corticosteroid treatment after heart transplant surgery, 3 had cancer, 3 had AIDS, 1 had diabetes mellitus, 1 had probable TB infection, 1 was undergoing renal dialysis, 1 had been hospitalized continuously for 3 or more days before onset of the Legionella infection, 1 had suspected exposure during travel in Brazil, and 6 indicated no underlying illness or possible exposure. There were 2 deaths; 30 survived, and the outcome for 2 was unknown.

LYME DISEASE (283)

5.9/100,000 (U.S. 3.5/100,000)

The trend of Lyme disease in Maryland from 1987 to 1991 is shown in Figure 8. In 1991 every jurisdiction, except Garrett and Washington, reported cases. The number of cases and incidence rates per 100,000 population by jurisdiction in 1989, 1990, and 1991 are shown in Table 3.

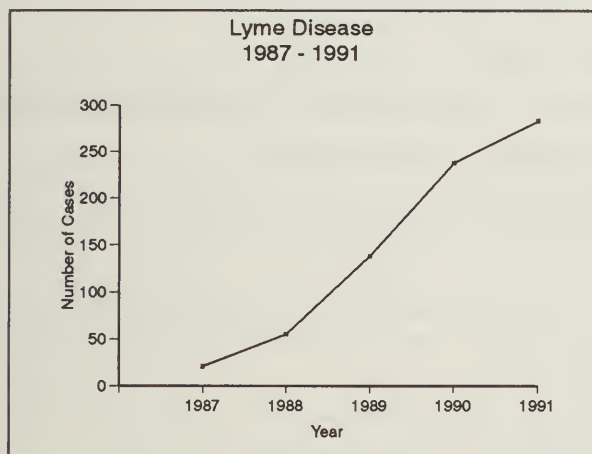


Figure 8

Eighty-three percent of the cases had onset of illness in April through September; the peak incidence was in June (66 cases) and July (53) (Figure 9).

The male to female ratio was 1.1:1.0. Among the cases with known race (272), 248 (91.2%) were white, 19 (7.0%) were black, 3 (1.1%) Hispanic, 2 (0.7%) other race. Ages ranged from 8 months to 88 years (mean 38, median 39 years). The highest

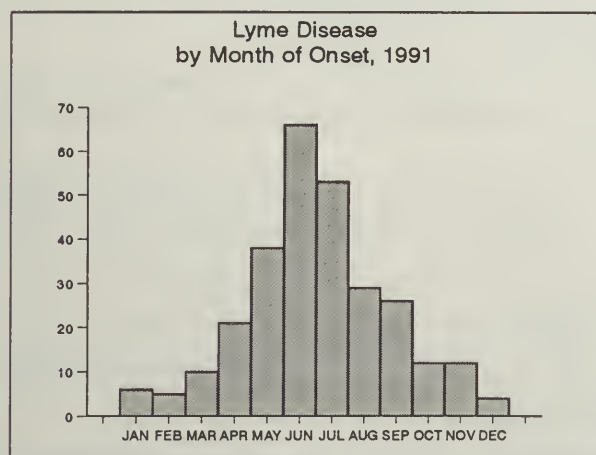


Figure 9

age-specific incidence rates per 100,000 population were observed in white males (13.3) and white females (9.2), 5 to 9 years of age, followed by the rates in white females (8.5) and in white males (7.6%), 25 to 49 years old.

Of those for whom information was available, 164 (59.2%) had erythema migrans, 151 (54.5%) had arthritis, 56 (18.9%) had erythema migrans and arthritis, 16 (5.8%) had Bell's palsy, 7 (2.5%) had cardiologic symptoms, 7 (2.5%) lymphocytic meningitis, 6 (2.2%) radiculoneuropathy, and 2 (0.7%) encephalitis. Forty-nine cases (19.6%) required hospitalization.

A definite tick bite prior to onset of illness was reported by 132 cases, 4 had no tick exposure, and for 147 there was no available exposure information.

TABLE 3. Lyme Disease Cases and Incidence Rates per 100,000 by Jurisdiction, 1989 - 1991

YEAR	1989		1990		1991	
COUNTY	N	Rate	N	Rate	N	Rate
Allegany	0	0.0	1	1.3	1	1.3
Anne Arundel	15	3.5	27	6.3	22	5.1
Baltimore City	6	0.8	12	1.6	10	1.4
Baltimore	21	3.1	39	5.6	49	7.0
Calvert	9	18.4	7	3.6	4	7.5
Caroline	2	8.1	3	11.1	22	80.2
Carroll	1	0.8	5	4.1	4	3.1
Cecil	7	10.0	15	21.0	30	37.6
Charles	14	14.0	23	22.7	10	9.7
Dorchester	3	10.0	1	3.3	5	16.3
Frederick	3	2.1	3	2.0	2	1.3
Garrett	0	0.0	0	0.0	0	0.0
Harford	4	2.4	27	14.8	18	9.8
Howard	3	1.7	10	5.3	7	3.7
Kent	11	64.7	9	50.4	12	69.9
Montgomery	15	2.1	13	1.7	11	1.5
Prince George's	8	1.1	10	1.4	8	1.1
Queen Anne's	11	33.0	10	29.5	27	79.6
St. Mary's	3	4.2	5	6.6	14	18.7
Somerset	0	0.0	0	0.0	2	8.7
Talbot	2	6.9	1	3.3	4	13.7
Washington	1	0.9	3	2.5	0	0.0
Wicomico	2	2.7	6	8.1	6	7.9
Worcester	2	2.7	8	8.1	15	38.5
TOTAL	143	3.1	238	5.0	283	5.9

To be concluded in October, 1992.

Third Annual Conference on Addiction: Physician Health & Education

Saturday, November 21, 1992 ■ 1211 Cathedral Street, Baltimore

Sponsored by the Medical and Chirurgical Faculty of Maryland Committee on Scientific Activity in Cooperation with the Physician Rehabilitation Committee

■ 7:30 am – 8:15 am Registration/Continental Breakfast

■ 8:15 am – 8:30 am Welcome
Jose M. Yosunico, M.D., President, Med Chi

■ 8:30 am – 10:00 am What is an Addiction?
This presentation will focus on various behaviors and patterns of substance use with the goal of identifying those disorders that respond to addictive disease treatment and are thus immediately labeled as addictions.

Speaker/Panel Moderator: John R. Steinberg, M.D., Clinical Assistant Professor, University of Maryland School of Medicine; President, Maryland Society of Addiction Medicine.

Panel: Stanley R. Platman, M.D., Professor, Department of Psychiatry, University of Maryland; Medical Director, Psychiatry, Union Memorial Hospital; Chairperson, Med Chi Physician Rehabilitation Committee

Maxwell N. Weisman, M.D., Director, Alcoholism Control Administration (ret.); Past President, American Society of Addiction Medicine (ASAM)

Objectives: Participants will be able to
a. describe the addiction process, and
b. compare and contrast chemical dependence (i.e. alcohol and drug abuse) and compulsive behaviors (e.g. gambling, over-eating) that have recently been referred to as addictions.

CME Credit: 1.5

■ 10:15 am – 11:15 am Concurrent Sessions

Session A: Narcotics and Tranquilizers: When is Use Abuse?

This presentation will highlight the differences between medically appropriate and addictive use of narcotics and tranquilizers.

Speaker: Rodney Burbach, M.D., Medical Director, Addiction Treatment Center, Suburban Hospital

Objective: Participants will be able to
a. identify commonly abused drugs, and
b. identify drug-seeking behavior.

CME Credit: 1

Session B: Effects of Tobacco on Psychotropic Medications

Speaker: To be announced

Objectives: Participants will be able to
a. identify psychotropic medications with which tobacco interacts, and
b. counsel patients who use such psychotropic medications in addition to tobacco.

CME Credit: 1

Session C: Litigation Stress

Speaker: To be announced

Objectives: Participants will be able to
a. assess the potentially disabling effects of stress as specifically related to malpractice litigation,
b. recognize the symptoms of such stress, and
c. manage such stress in their own lives.

CME Credit: 1

■ 11:30 am – 12:30 pm Patient Placement Criteria Manual (PPCM)

Developed over the past several years, the American Society of Addiction Medicine PPCM is designed to aid physicians in the diagnosis and facilitation of treatment planning for their addicted patients.

Selection of patients for level of care attending to severity of addiction as measured by bio-psycho-social criteria.

Speaker: Barton A. Harris, M.D., Chief, Addiction Medicine, Fort Howard and VAMC-MD

Objectives: Participants will be able to
a. explain the purpose of the manual, and
b. use the manual in the diagnosis and treatment planning of addicted patients.

CME Credit: 1

■ 12:30 pm – 1:30 pm Lunch (Buffet lunch provided for all registrants)

■ 1:45 pm – 2:45 pm Sexual Misconduct in the Practice of Medicine

Speaker: Charles H. Epps, Jr., M.D., Dean, College of Medicine, Howard University; Member, AMA Council on Ethical and Judicial Affairs

Objectives: Participants will be able to

- define the AMA's policy on sexual activity between physician and patient, and
- explain the evolution of that policy including the negative factors of and serious harm caused by such a relationship.

CME Credit: 1

■ 3:00 pm – 5:00 pm Identification and Treatment of the Substance-Abusing Patient

Speaker: Kevin S. Ferentz, M.D., Assistant Professor of Family Medicine, University of Maryland; Director, Student and Employee Health

Objectives: Participants will be able to

- understand the positive and effective role primary care physicians have in treating substance-abusing patients,

- recognize and understand how to use several easy to use substance abuse screening questionnaires and laboratory tests used to assess alcohol and drug problems, and

- describe some techniques and strategies for counseling patients with substance abuse problems.

CME Credit: 2

■ 5:15 pm – 6:15 pm UPDATE: How to Help Your Patients Stop Smoking

Speaker: Kevin S. Ferentz, M.D., Assistant Professor of Family Medicine, University of Maryland; Director, Student and Employee Health

Objectives: Participants will be able to

- identify and use strategies and techniques to encourage patients to stop smoking, and
- explain the benefits/consequences of prescribing nicotine (gum, patches, etc.) to patients.

CME Credit: 1

The Medical and Chirurgical Faculty is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

The Medical and Chirurgical Faculty designates this continuing medical education activity for up to 7.5 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

This schedule is preliminary. Times, speakers and topics are subject to change.

Third Annual Conference on Addiction: Physician Health & Education

Registration Form

Check One:

- ☐ Med Chi members – \$50
☐ Physician nonmembers/PhDs – \$100
☐ Allied Health Professionals – \$25
☐ Students and Residents – NO CHARGE

Form of Payment:

- ☐ Check (payable to Med Chi)
☐ VISA/MASTERCARD

Credit Card No. _____

Exp. Date _____

Signature: _____

Name _____

Address _____

City _____ State _____

Zip _____ Phone _____

Please indicate your breakout session preference: (refer to schedule for topic)

10:15 a.m. – 11:15 a.m.

☐ A

☐ B

☐ C

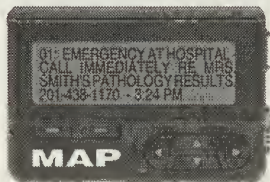
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For each course, additional information may be obtained by contacting the Program of Continuing Education, University of Maryland School of Medicine, Room 14-011, BRB, 655 W. Baltimore St., Baltimore, MD 21201 (410-328-3956) or by calling the phone number listed after a specific program. FAX 410-328-3103.

Colloquium and workshops on laryngeal disorders. Cat 1 AMA/PRA credit available. Fee: \$500 physicians; \$200 residents, fellows, and allied health professionals.	Sept. 10-12
Topics in pulmonary medicine, at the Baltimore Marriott Inner Harbor Hotel, Baltimore, MD. 8 Cat 1 AMA/PRA credits. Fee: \$175 physicians; \$125 allied health professionals, interns, residents, and fellows. Info: Larry R. Saunder, 410-328-4497.	Sept. 12-13
HIV coordinator skills course, sponsored by the Maryland AIDS Professional Education Center, in Salisbury, MD. Info: Gwen Kergides, 410-328-8639.	Sept. 24-25
HIV counseling skills I, sponsored by the Maryland AIDS Professional Education Center, in Annapolis, MD. Info: Gwen Kergides, 410-328-8639.	Oct. 19-22
AIDS: A challenge to primary care—4th annual conference, sponsored by the Maryland AIDS Professional Education Center, in Baltimore, MD. Info: Gwen Kergides, 410-328-8639.	Oct. 26-27
HIV advanced counseling skills II, sponsored by the Maryland AIDS Professional Education Center, in Hagerstown, MD. Info: Gwen Kergides, 410-328-8639.	Nov. 19-20
HIV counseling skills I, sponsored by the Maryland AIDS Professional Education Center, in Baltimore, MD. Info: Gwen Kergides, 410-328-8639.	Dec. 8-11

Continuously throughout the year

Visiting professor program. A 1992 directory of speakers and their topics is available to area hospitals and other health care organizations. NO administrative fees are charged for this service. Info: 410-328-3956.

Visiting fellowship in interventional radiology. Five-day practicum for radiologists, including conferences, patient rounds, and laboratory observations. By appointment only. 40 Cat 1 AMA/PRA credit. Fee: \$1,200.

Ultrasound: Preceptorships. For physicians or sonographers with six-months experience in practicing ultrasound. By appointment only. 40 Cat 1 AMA/PRA credit. \$500.

Departmental rounds and conferences. Weekly, hands-on, and lecture presentations hosted by the University's clinical departments. Hour-for-hour Cat 1 AMA/PRA credits available. Brochure available.

Pediatric grand rounds. Every Thursday from September to June, except third Thursday, in the R. Adams Cowley Shock Trauma Auditorium. Info: Bonnie Winters, 410-328-6777.

CME LECTURERS NEEDED IN THE VIRGIN ISLANDS

The U.S. Virgin Islands has a very small medical society (VIMS) with only two continuing medical education (CME) sponsors: the St. Croix Hospital and the St. Thomas Hospital. Both hospitals have well-organized, active CME committees, but both have difficulty obtaining qualified speakers for CME programs.

Although VIMS cannot afford to offer stipends, travel expenses, or lodging, it would appreciate having qualified physicians—who choose to vacation in the Virgin Islands—provide a CME lecture as per ACCME provisions.

Interested physicians are encouraged to call Dr. Angelo Galiber, St. Croix Hospital Staff CME director, at 809-778-5305; Dr. Brian Cheetham, St. Thomas Hospital CME chairperson, at 809-774-0506; or Dr. Francis J. Farrell, VIMS Accreditation Committee chairperson, at 809-778-6400 or 809-776-0506.

Miscellaneous meetings

- Initial thoughts on the city and state:** Dean Donald Wilson, M.D., sponsored by the Baltimore City Medical Society, at St. Agnes Hospital. 1 Cat 1 AMA/PRA credit; 1 AAFP prescribed hour. Fee: none. Info: Lorraine Wallace, 410-625-0022. **Sept. 3**
- Maryland Chapter of the American College of Surgeons annual fall meeting,** at the Harbor Court Hotel, Baltimore, MD. 3 Cat 1 AMA/PRA credits. Fee: none. Info: Dr. Frederick Walker, 410-836-0909. **Sept. 19**
- USP open conference on patient education,** at the Bethesda Marriott Hotel, Bethesda, MD. Fee: \$225 academic and government; \$425 industry, association, consultant, and public. Info: 301-816-8374. **Sept. 21-23**
- 4th annual trauma conference,** sponsored by the Peninsula Regional Medical Center, at the Sheraton Ocean City Resort and Conference Center, Ocean City, MD. Cat 1 AMA/PRA credits available. Fee: \$200. Info: Darlene Kwiatkowski, 410-543-7328. **Sept. 24-25**
- Nutrition in the 90s and nonhypertensive cardiology update,** sponsored by the Maryland Academy of Family Physicians (MAFP), at the Host Golf Resort and Conference Center, Lancaster, PA. 5.25 Cat 1 AMA/PRA credits; 5.25 AAFP prescribed hours. Fee: \$55 MAFP members; \$80 nonmembers; \$35 paramedicals; no charge residents, medical students, MAFP retired and life members. Info: William P. Jones, M.D., 410-747-1980. **Sept. 26**
- Traditional Chinese medicine,** sponsored by the Baltimore City Medical Society, at Harbor Hospital Center, Baltimore, MD. 1 Cat 1 AMA/PRA credit; 1 AAFP prescribed hour. Fee: none. Info: Lorraine Wallace, 410-625-0022. **Oct. 1**
- New techniques and concepts in cardiology,** sponsored by the American College of Cardiology, at the Hyatt Regency Hotel, Washington, DC. 16 Cat 1 AMA/PRA credits. Info: Registration Secretary, 800-257-4739. **Oct. 22-23**
- Sixth annual national disability management conference and exhibit,** sponsored by the Washington Business Group on Health (WBGH), at the Crystal Gateway Marriott, Arlington, VA. Fee: \$400 WBGH members; \$475 nonmembers. Info: 202-408-9320. **Oct. 26-27**
- International standards update,** sponsored by the Association for the Advancement of Medical Instrumentation, in Washington, DC. Info: 703-525-4890, ext. 212 or 210. **Nov. 10**
- Arthritis care for the 1990s: A practical approach for the primary care physician,** sponsored by the Arthritis Foundation, Maryland Chapter, at the Sheraton Inner Harbor Hotel, in Baltimore, MD. Cat 1 AMA/PRA credits available. Fee: \$45, \$30 if not requesting CME. Info: Karen Krug, 410-561-8090 or 800-365-3811. **Nov. 14**
- Williamsburg conference on heart disease,** sponsored by the American College of Cardiology at the Williamsburg Conference Center, Williamsburg, VA. 18 Cat 1 AMA/PRA credits. Info: 800-257-4739. **Dec. 6-9**
- Cardiovascular science and technology conference,** sponsored by Association for the Advancement of Medical Instrumentation, Washington, DC. Info: 703-525-4890, ext. 210 or 212. **Dec. 12-14**

Continuously throughout the year

- Fluorescein angiography conference,** sponsored by the Retina Center, St. Joseph Hospital, Baltimore, MD, first and third Mondays of each month; 8:00-9:00 a.m. Fee: none. Info: R. Classon, 410-337-4500.

Shady Grove Adventist Hospital

9901 Medical Center Drive, Rockville, MD. Info: 301-279-6115.

Anovulation and its treatment.	Sept. 3
The noninvasive peripheral vascular lab.	Sept. 10
GI manifestations of stress.	Sept. 17
Current management of atrial fibrillation & flutter: A 1992 update.	Sept. 24
Special considerations for the elderly arthritic patients.	Oct. 1
Update on discharge planning services.	Oct. 8
The retina.	Oct. 29
Risk management.	Nov. 5
Diabetes.	Nov. 12

The Johns Hopkins Medical Institutions

All courses at the Turner Auditorium unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Education, 720 Rutland Ave., Baltimore, MD 21205 (410-955-2959).

Laryngeal disorders: Hands-on colloquium, laboratory, and workshops. Cat 1 AMA/PRA credits pending. Fee: \$1,000 colloquium and lab; \$400 colloquium for physicians; \$225 colloquium for residents and allied health professionals.	Sept. 10-12
Annual update on obstetric anesthesia, at Stouffer Harborplace Hotel, Baltimore, MD. 8 Cat 1 AMA/PRA credits. Fee: \$150 physicians; \$25 residents and fellows.	Sept. 12
Pediatrics for the practitioner—Update 1992. Cat 1 AMA/PRA credits available. Fee: TBA.	Sept. 17-18
21st annual diagnostic ultrasound in gynecology and obstetrics and abdomen, at the Stouffer Harborplace Hotel, Baltimore, MD. 16.5 Cat 1 AMA/PRA credits. Fee: 3 days, physicians \$400, others \$300; 2 days, physicians \$300, others \$225; 1 day, physicians \$150, others \$125.	Sept. 25-27
18th annual topics in gastroenterology and liver disease. Cat 1 AMA/PRA credit available. Fee: TBA.	Sept. 30- Oct. 2
34th annual Emil Novak Memorial Course: Gynecology, gynecological pathology, endocrinology, and high-risk obstetrics. 53 Cat 1 AMA/PRA credits; 51 ACOG cognates. Fee: \$675 physicians; \$475 residents, fellows, and allied health professionals.	Oct. 12-17
Core content of emergency medicine: A comprehensive review, at the Marriott Hotel, Baltimore-Washington International Airport, Baltimore, MD. Cat 1 AMA/PRA credits and ACEP credits available. Fee: \$1,000; \$75 ultrasound workshop; \$125 computer lab; \$75 wound closure/care lab.	Oct. 17-23
Diabetic retinopathy. 8 Cat 1 AMA/PRA credits. Fee: \$200 physicians; \$100 residents, fellows, and allied health professionals.	Oct. 23
Update on sinusitis for the practitioner. 9 Cat 1 AMA/PRA credits. Fee: \$175 physicians; \$95 residents, fellows, and allied health professionals.	Oct. 30
Hemodynamic monitoring, patient care, and pulmonary artery catheterization—A hands-on course. 14 Cat 1 AMA/PRA credits. Fee: \$575.	Oct. 31- Nov. 1
Advanced pediatric life support courses. 20 Cat 1 AMA/PRA credits. Fee: TBA.	Nov. 2-4

CME PROGRAMS CME PROGRAMS CME PROGRAMS CME PROGRAM

Progress in pediatrics. 11 Cat 1 AMA/PRA credits. Fee: \$140 physicians; \$80 residents, fellows, and nurse practitioners.	Nov. 6-7
Horizons in transplantation. 6.5 Cat 1 AMA/PRA credits. Fee: \$45.	Nov. 13
Neural mechanisms of the auditory and vestibular systems II. Cat 1 AMA/PRA credits available. Fee: \$375 physicians; \$300 residents and fellows; \$450 allied health professionals.	Dec. 1-2
Clinical management of vestibular disorders. Cat 1 AMA/PRA credits available. Fee: \$375 physicians; \$300 residents and fellows; \$450 allied health professionals.	Dec. 3-4
The Wilmer Ophthalmological Institute's current concepts in ophthalmology. 20 Cat 1 AMA/PRA credits. Fee: \$300 physicians; \$250 residents, fellows, and allied health professionals.	Dec. 10-12

Continuously throughout the year

- Visiting preceptorship in pediatric critical care medicine.** Ongoing five-day preceptorship by appointment. 40 Cat 1 AMA/PRA credits. Fee: \$600.
- The department of radiology and radiological sciences** offers several courses in abdominal and obstetrical ultrasound. Info: P. Williams, 410-955-3169.
- Visiting physicians.** Offered throughout the year for experience in the lab and participation in read-in sessions; by appointment only. 40 Cat 1 AMA/PRA credits. Fee: \$500.
- Johns Hopkins medical grand rounds.** Accredited audiovisual continuing education series of case discussions for clinicians; thirty topics per year in five bimonthly programs. Individual and group subscriptions. 40 Cat 1 AMA/PRA credits. Info: 410-955-3988.

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American Medical Association Works to Redress Medicare Inequities

The American Medical Association is working to enact legislation in Congress to redress several inequities in the Medicare program.

New Physicians: Senate bill 2362 and House bill 4507 ask for repeal of provisions in the current law that mandate Medicare payment reductions for physicians in their first four years of providing care for Medicare beneficiaries.

EKGs: House bill 3373 and Senate bill 1810 would restore Medicare reimbursement for interpreting EKGs. HCFA says that it did not add sufficient money to visit codes to cover expected costs of paying for interpretation. The AMA, HCFA and medical specialty societies are

discussing ways to recoup the money.

Geographic Price Cost Indices: HR 4393 and S 2680 would require HHS to use more accurate current data and consult with the state medical societies to revise the GPCIs. S 2683 requires HCFA to update GPCIs more frequently and make special adjustments for physicians in isolated areas.

Anti-Hassle: HR 2695 and S 1332 aim at reducing administrative hassles regarding secondary payors, payment errors, carrier user fees, and improving physician peer review.

Contact your senators and representatives to ask them to cosponsor these bills: 1-202-224-3121.

AMA Censures Disruptive CLIA Office Visits

The AMA, in comments on the final CLIA regulations, characterized unannounced HCFA inspections as disruptive for patients, especially those waiting for test results. The AMA

recommended that inspectors:

- treat physician's offices differently from independent reference labs, and
- notify physicians ahead of time.

The AMA and Medical Liability: Principles of Reform

The American Medical Association believes that as the national debate on health care reform proceeds, we must address its high cost, inefficiency and inequity of our medical liability system.

The Problem

People injured by medical malpractice or defective medical products are entitled to fair and prompt compensation for their injuries. All parties should have the right to fair and cost-effective dispute resolution. The AMA believes that in resolving medical and product liability claims, the civil justice system currently:

- Costs too much and works slowly;
- Fails to provide access to the legal system or fair compensation to most patients, while providing exorbitant awards to others;
- Is unable to promptly or cost-effectively identify unfounded claims;
- Fails to promote quality health care or protect patients from avoidable injuries;
- Adds billions annually to the national health care bill in medical liability premium costs and by encouraging doctors to practice "defensive medicine" to hedge against potential lawsuits;
- Threatens access to health care, especially high risk services, such as obstetrics and emergency room care;
- Unnecessarily adds to the cost of pharmaceuticals and medical devices, and
- Inhibits health care product research and development, reducing the availability of potentially valuable new drugs and medical devices.

The impact of our medical liability system has been studied extensively. These studies agree that this inefficient system adds to the serious problems of making health care services available to all and making these services cost-effective.

The federal government, as the single largest purchaser of health care services, has a strong interest in promoting available and quality medical

care and managing its cost. Because of that concern, it should take the lead to address medical liability problems.

Principles of Medical Liability Reform

The over 100 groups including the AMA that participate in the **National Medical Liability Reform Coalition** support the principles articulated below. These principles should guide any restructuring of the current medical liability system.

1. Availability of Health Care:

A compensation system for medical injury should promote the basic goal of providing access to all necessary health care service to all.

2. Quality of Health Care:

A compensation system for medical injury should deter substandard or unethical practices and encourage improvements in the safety and quality of medical care.

3. Patient-Professional Relationship:

A compensation system for medical injury should enhance a cooperative relationship between patient and providers, based on mutual respect and effective communication.

4. Fair Compensation:

A compensation system for medical injury should compensate patients injured by malpractice adequately and equitably.

5. Prompt Resolution: A compensation system for medical injury should resolve claims promptly.

6. Innovation: A compensation system for medical injury should encourage innovation in diagnosis and treatment, leading to better care.

7. Predictability: A compensation system for medical injury should provide predictable outcomes with respect to findings of liability and amount of awards.

8. Cost Effectiveness: A compensation system for medical injury should operate efficiently and economically.

We urge the Congress and the President to work on meaningful medical liability reform legislation consistent with the above principles.

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Information for AUTHORS

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2. Ropes MW. Characteristics, manifestations, and pathologic findings. In: Ropes MD, ed. *Systemic Lupus Erythematosus*. Cambridge, MA: Harvard University Press. 1976; 50-4.

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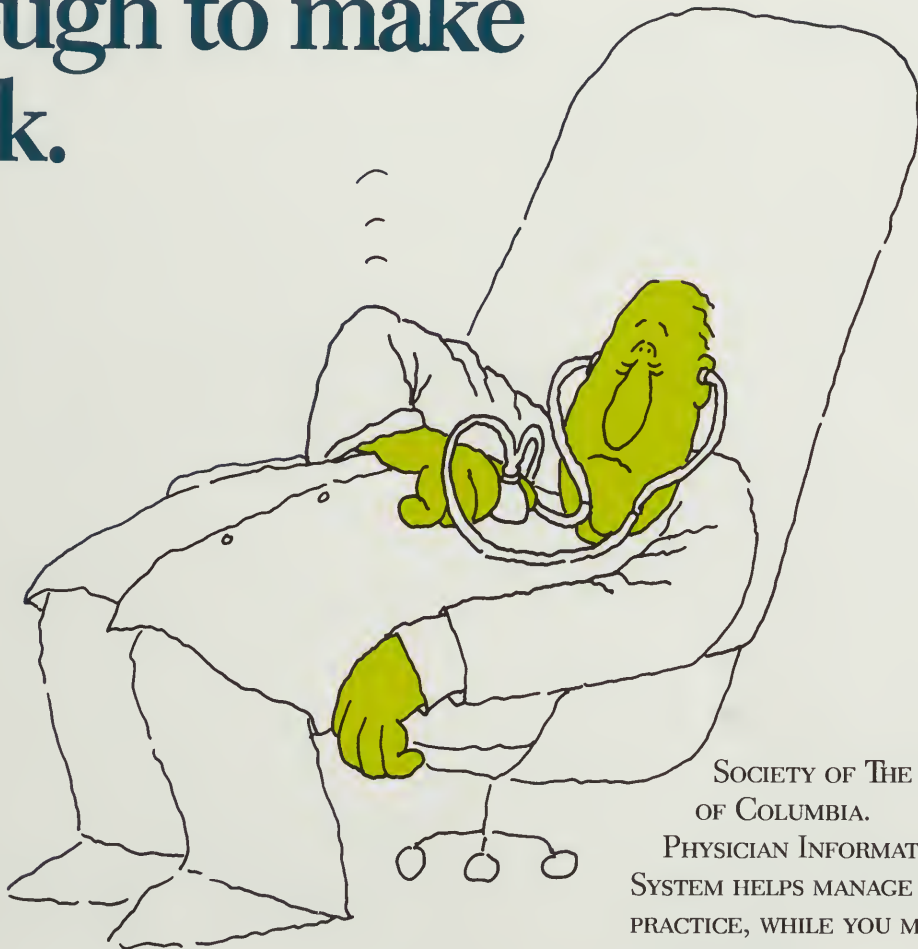
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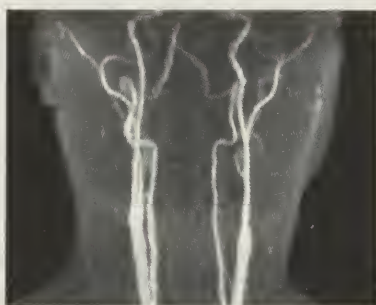


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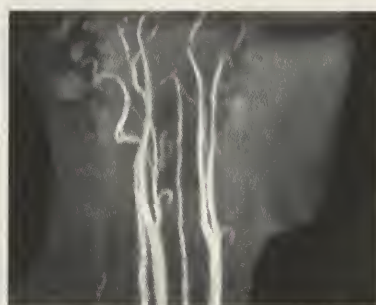
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VOLUME 41 NO 10

On deaning and Hopkins: An interview with Richard S. Ross, M.D., dean emeritus of the Johns Hopkins University School of Medicine 887

Janet Farrar Worthington

Dr. Ross served as dean from 1975 to 1990. In June 1991, Hopkins dedicated its major new medical research building in his name.

Richard S. Ross, M.D.—dean emeritus of the Johns Hopkins University School of Medicine: An interview with MMJ's editor 888

Betsy Newman

Papillary muscle rupture: A reversible cause of cardiogenic shock 893

Eric Chwa, M.D.; Angeles Gonzalez, M.D.; Raymond D. Bahr, M.D.; Anil Fatterpaker, M.D.; Alfred Cassale, M.D.; and Raymond E. Gillilan, M.D.

Acute papillary muscle rupture after myocardial infarction, with accompanying pulmonary edema and cardiogenic chock, is an emergnecy condition leading to high mortality without surgical treatment.

Instrumental musicians showing technique impairment with painful overuse 899

Hunter J. H. Fry, M.S., F.R.C.S., F.R.A.C.S. and Glen Rowley, Ph.D.

Among musicians, musculo-ligamentous overuse, or overuse syndrome, is the most common cause of pain in the upper limbs. Impairment of technique can be the reuslt of painful overuse, or it may be the antecedent of it.

Medical peer review, litigation, and the exercise of judgment 905

Jesse M. Hellman, M.D.

The ambiguity, complexity, and uncertainty that characterize physician discussions of quality care are an inherent and necessary part of the peer review process.

CASE REPORT: Primary tumors of the ovary and colon associated with pseudomyxoma peritonei 909

Ira R. Horowitz, M.D.; Douglas Lakin, M.D.; Gayatri Ramani, M.B.B.S., M.S.; and John L. Currie, M.D.

The patient presented had primary tumors of the ovary and colon in association with pseudomyxoma peritonei. Since pseudomyxoma peritonei has been associated with mucin-producing tumor of the genital and gastrointestinal tract, a thorough evaluation of the gastrointestinal tract should be performed in patients thought to have pseudomyxoma peritonei secondary to an ovarian neoplasm.



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In this issue of the journal, we present two new departments: "When the Doctor is Out" will highlight Med Chi physicians who have unusual hobbies or who are engaged in uncommon activities. "A Look Back" will reprint articles from early issues of the journal to illustrate the dramatic changes that have occurred in medicine, as well as the many facets of medicine that have stayed the same.

Cover photograph and design by Virginia Carter

Cover: Richard S. Ross, M.D., dean emeritus of the Johns Hopkins University School of Medicine, in front of the new research building that bears his name.

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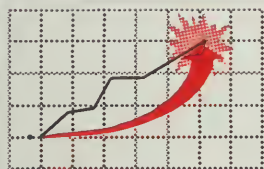
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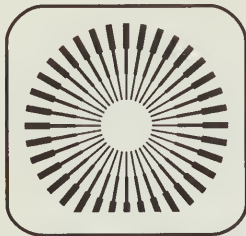
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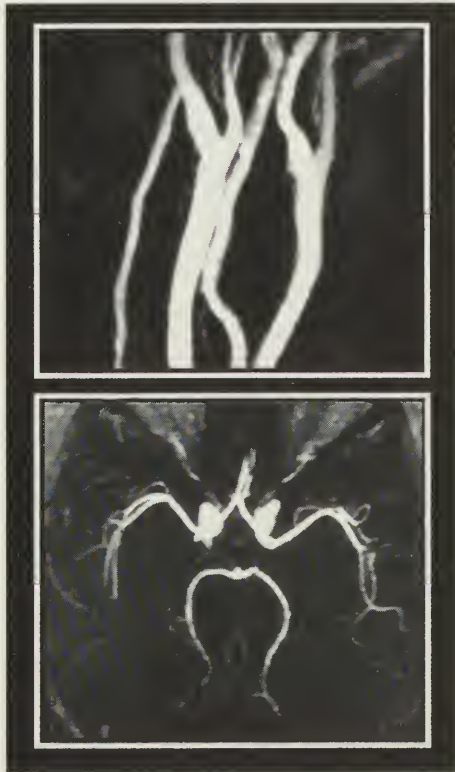


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Executive Director's Newsletter

October 1992

Med Chi Sponsors Forum on Health Care Reform

More than 250 physicians attended Med Chi's "Forum on Health Care Reform" on September 19, 1992 at the 1992 semiannual meeting in Ocean City, Maryland. During the session, Med Chi physicians listened to a panel discussion of major health care reform issues at the state and federal levels.

Mary Stuart, Sc.D., director of Policy and Health Statistics for the Department of Health and Mental Hygiene (DHMH), reviewed the results of several initiatives at the state level including the Maryland Access to Care program (MAC) and the Healthy Start program. She attributed the success of these programs to the efforts made by Maryland physicians. Mandell Bellmore, Ph.D., vice-chairperson of Governor Schaefer's Commission to Study Health Care Issues in Maryland, gave an initial presentation of the commission's findings. Donald Dembo, M.D., chairperson of Med Chi's Committee on Managed Care and Third-Party Liaison, reviewed other state initiatives on health care reform. The Honorable Benjamin L. Carson reviewed health initiatives at the federal level including his proposed Flex Med program. Joseph Painter, M.D., president-elect of the American Medical Association (AMA), concluded the panel discussion with a review of the AMA's Health Access America program.

Following the program, many physicians questioned panel speakers regarding the future of our health care system. It was a consensus opinion that, whatever the reform proposal, physicians must remain unified in order to ensure that patients receive the quality health care they deserve. A monograph of these proceedings is being developed, and copies of materials that were presented during the session are free to members. To order, contact the Med Chi Communications Department at 410-539-0872 or 1-800-492-1056.

Resolutions Passed at Semiannual Meeting

The House of Delegates discussed many issues affecting Maryland medicine during the 1992 semiannual meeting. A summary of several important House of Delegates decisions is provided below:

1. The House moved to designate an ad hoc committee, to be appointed by the president, to study the issue of self-referral. The House also moved to inform legislators that Med Chi reaffirms its support of the current 1991 Maryland State Disclosure Law and Senate Bill 654—the Board of Physician Quality Assurance bill that provides a mechanism to monitor and censure overutilization. Med Chi will also inform legislators of the formation of an ad hoc committee to study the issue of self-referral and self-referral legislation.

2. The House moved that Med Chi take no position on the issue of abortion (re: referendum question six on the November ballot).
3. The House passed the following resolution:
Resolved, That the American Medical Association draft and use its best offices to have enacted national legislation to require that the owner and operator of a firearm meet certain criteria, similar to the criteria that the owner and operator of a motor vehicle must meet, i.e., be of a certain age, physical and mental condition, and be required to demonstrate knowledge and skill in proper use of that firearm.
4. The House also passed a resolution that deals with the imprinting of solid oral dosage form drug products:
Resolved, That the Medical and Chirurgical Faculty of Maryland adopt as its policy an intention to see legislation introduced into the Maryland General Assembly calling for the statutory requirement of imprinting for identification all generic solid oral drug products.
5. The House also made numerous changes to Med Chi's *Bylaws*. The changes are detailed in the House of Delegates minutes, which will be published in a future issue of the *MMJ*.

*Awards Presented at
1992 Semiannual
Meeting*

Med Chi President Jose M. Yosunico, M.D. presented a number of awards during the 1992 semiannual meeting. These included a governor's citation for Donald T. Lewers, M.D. for his work with the American Medical Association. Auxilian Mrs. Elizabeth Lindhardt received a governor's citation and a Med Chi certificate of recognition for her work over the past several years in coordinating the AMA/ERF funds. I. Rivers Hanson, M.D. received a 50-year membership award.

Dr. Yosunico also announced winners of the *Maryland Medical Journal (MMJ)* best article awards. Mary Betty Stevens, M.D. received the practitioner award for her article "Clinical Spectrum of SLE," which appeared in the October 1991 *MMJ*. "Inflammatory Pseudotumor of the Retroperitoneum," in the September 1991 *MMJ* by Santa J. Johnston, M.D. et al won the resident award.

The winners of the Seventh Annual Media Awards program were also named. They are

Daily Newspaper Category

Marol Barnhard, "Harold Churchey: Man with a Vision," *The Herald Mail*, Hagerstown, MD

Non-Daily Newspaper Category

Jeanne Beach, "Attention Turns to Alzheimer's", Homestead Publishing Company

Special Mention:

Lynne Salisbury, "Balancing Acts: How Young People and Their Families Cope with Diabetes," *Columbia Flier*

Radio Category

Marian Koubek, "An Element of Danger," WPOC-FM

Television Category

Lisa Willis and Scott Livingston, "Around the Clock Care," WBFF-TV

Mammography Screening

Effective September 8, 1992, on-site surveys of screening mammography suppliers were initiated. The Health Care Financing Administration has directed the Office of Licensing and Certification Programs to perform *unannounced* surveys. Inquiries concerning this issue can be directed to William Dorrill, deputy director, Hospitals and Ambulatory Care Services, 410-764-4980.

Medicare Policy on Pneumococcal and Hepatitis B Vaccines

The Health Care Financing Administration has clarified Medicare's policy regarding payment for pneumococcal and hepatitis B vaccines (procedure codes 90732 and 90731). Since the physician fee schedule allowances for these vaccines do not include an allowance for administration, an administration fee may be billed in addition to the fee for the vaccines, using procedure codes 90782-90784. If a visit is rendered in conjunction with the administration of these vaccines, payment will be made for the cost of the drug, the administration fee, and the visit.

CLIA Update

Louis Sullivan, M.D., secretary of Health and Human Services, outlined several important changes for physicians affected by the Clinical Laboratory Information Act (CLIA). These changes include

1. The process of surveying clinical labs will begin with the largest labs. The first biannual inspections of physicians' facilities will not take place until 1993-1994.
2. The purpose of the initial inspections of physician facilities will be educational. If inspectors find a lab that does not meet CLIA standards, the lab owners will be asked to comply with the standards and will be provided with technical assistance. Sanctions will be applied only if conditions pose immediate jeopardy to patients.
3. Laboratories located in physician offices in which unannounced inspections could disrupt patient care will be surveyed on an announced basis.
4. A 90-day grace period has been granted. The deadline to register with the Health Care Financing Administration (HCFA) as required by CLIA has been extended from September 1 to December 1, 1992.

Provider Fee Project

The Provider Fee Project ended on June 30, 1992. Upper payment limits will no longer be used to calculate provider reimbursements, and they are being eliminated from the regulations.

Medical Staff Bylaws

The AMA's Office of the General Counsel has reported that hospitals are presenting their medical staff with bylaw amendments addressing disruptive physician behavior. The AMA has advised medical staffs to develop their own policies on disruptive behavior to include objective standards limiting disciplinary action to instances that compromise patient care.

Deaf Patients

Physicians have been incorrectly informed that they face discrimination charges under the Americans with Disabilities Act unless they provide a qualified sign-language interpreter during patient office visits. The AMA's Office of the General Counsel has advised that the act does not mandate the use of a qualified interpreter for every physician encounter and has suggested that physicians consult with their hearing-impaired patients about how they prefer to communicate. In most instances, physicians may meet the requirements by using written notes or listening devices instead of hiring an interpreter.

*Florida Hurricane Relief
Foundation*

The Florida Medical Association (FMA) has formed the Florida Medical Foundation/Hurricane Relief Fund. There is an immediate need for money to assist those whose losses may be only partially insured or who will need help beyond insured losses. Those wishing to make tax deductible contributions should make their check payable to the "Florida Medical Foundation/Hurricane Relief Fund" and mail it to

Florida Medical Foundation/Hurricane Relief Fund
P. O. Box 2411
Jacksonville, FL 32203

The staff contact person for the fund is Cynthia B. Jackson, director, FMA Division of Finance. She may be reached at 904-356-1571 or fax inquiries to her at 904-353-1247.

Hurricane Iniki

The Hawaii Medical Association (HMA) has reported that both the Samuel Mahelona and Waimea hospitals were without power and water as late as the end of September. Estimates indicate that more than 10,000 residents became homeless and were exposed to disease.

The HMA Community Research Bureau has established a relief fund for residents affected by the hurricane. HMA asks those physicians who can not volunteer their time to donate to the relief fund. HMA's Community Research Bureau is administered by the HMA Council and is a 501(c)3 organization authorized to accept tax-deductible donations.

Contributions may be mailed to the HMA Community Research Bureau, 1360 S. Beretania Street, 2nd Floor, Honolulu, HI 96814.

*Doctors Requested to
Report Key T-Cell Data
to the CDC*

The American Medical Association (AMA) is requesting its member physicians, as well as other health care providers, to report key T-cell patient information to the Centers for Disease Control (CDC). The AMA is requesting that physicians report to the CDC, through the AIDS surveillance section of their local or state health department, patients who have all of the following

1. CD4+ T-lymphocyte depletion (absolute CD4 T-cell level less than 300 cells/ μ L or less than 20 percent on more than one determination)
2. No serologic evidence of HIV infection
3. No defined immunodeficiency or therapy associated with T-cell depletion.

Although no cases have been reported in children, HIV-negative pediatric cases with unexplained depletion of CD4 cells (as defined by age-adjusted normal CD4 counts) should also be reported.

This request is made in order to assist the CDC in determining the extent of the syndrome of CD4+ lymphocyte depletion in persons without evident HIV infection.

*County Health Officers
to Meet at Med Chi*

On October 15, 1992, Med Chi will meet with the Maryland Association of County Health Officers (MACHO) to discuss the ramifications of recent state health budget cuts. Med Chi intends to keep physicians apprised of events resulting from this meeting. Watch the *Executive Director's Newsletter* for more details.

1993 CPT Coding Books

Med Chi's library will have 1993 CPT books (Current Procedural Terminology) for sale, beginning in late December 1992 or early January 1993. The price will be \$36.00 if picked up at Med Chi or \$38.00 if sent via UPS.

The library also anticipates having 1993 ICD books (International Classification of Diseases) by December 1992. The price for ICD books has not been set at this time.

Please note that these items are not available at the current time. The library does have a limited number of 1992 ICD coding books available at a reduced price of \$40.00. All CPT and ICD book orders must be pre-paid. For further information, please contact Susan Harman or Rosalind Ellen in the library at 410-539-0872 or 1-800-492-1056.

Membership Directory
Changes

Changes to the 1992-1993 *Membership Directory* are featured on pages 941 to 943 of this *Maryland Medical Journal*. If your *directory* listing has changed or contains incorrect information, please contact Wanda Griebel in Med Chi's Membership Department at 410-539-0872 or 1-800-492-1056.

Med Chi Handbook

The 1992-1993 *Med Chi Handbook* is currently available to Med Chi members. The *handbook* is an excellent reference for many Med Chi activities and contains listings of all Faculty officers, committees, component medical societies, and specialty societies. Committee member listings in this year's *handbook* include a complete address for the purposes of committee correspondence.

The *handbook* features a listing of physicians serving as liaisons to other organizations including gubernatorial appointments and Department of Health and Mental Hygiene appointments. Members can order a free copy of the *handbook*, by calling the Med Chi Communications Department at 410-539-0872 or 1-800-492-1056.

If you currently have a 1992-1993 *handbook*, please note the following changes (changes in bold):

page 2

Benjamin Maldonado, M.D.,
Prince George's County
1-301-599-8180

Alex Azar, M.D.,
Wicomico County,
1-410-546-2500

Albert L. Blumberg, M.D.,
Baltimore County,
1-410-828-2540

page 3

Paul A. Stagg, M.D.
Dorchester County
1-410-221-2300

page 5

Alternate Delegates to the AMA
Robert Ferris 410-366-8340
Student Component

page 7

President
Jose M. Yosucio, M.D.
1-410-522-8233

page 14

Paul A. Stagg, M.D.,
Dorchester County
1-410-221-2300

page 22

Officers
Alex Azar, M.D.,
third vice-president
1-410-546-2500

page 36

Finance Committee
Paul A. Stagg, M.D., *chairperson*
1-410-221-2300

page 45

Perry Hookman, M.D.
6001 Landover Road
Suite 4
Cheverly, MD 20785
1-301-773-1111

page 46

Committee on Managed Care
and Third-Party Liaison
Stephan L. Werner, M.D.
Greenbelt, MD 20770

*Med Chi Calendar of
Events*

It would be appreciated if you would notify Med Chi of any inaccuracies in the *handbook*. For corrections or questions about the *handbook*, please contact Arlene H. Whalen at 410-539-0872 or 1-800-492-1056 (ext. 307).

*President's Regional
Conference—Western
Maryland*

Thursday, October 22, 1992, at 4:30 p.m.
at the Sheraton in Hagerstown, Maryland

This conference is for members in Garrett, Allegany, Washington, Frederick, and Carroll counties. Conference topics include Medicare reimbursement and a legislative update. The meeting will also feature a one-hour continuing medical education presentation on

"Medical Management in Home Care"

Speakers:

George A. Taler, M.D., chairperson, Med Chi Committee on Long-Term Care and Geriatrics, and assistant professor of Family Practice at the University of Maryland School of Medicine

Carol C. Sylvester, M.S., director of the Department of Home Care Services, the Johns Hopkins Hospital.

Objectives:

Participants will be able to identify the needs of the home-bound elderly, identify community resources for the elderly, and practice appropriate medical management of the elderly at home.

CME credit: 1.0*

For more information about this conference, contact Joan Mannion in Med Chi's Continuing Medical Education Department at 410-539-0872 or 1-800-492-1056.

*President's
Regional Conference—
Eastern Shore*

Thursday, November 5, 1992 at 4:45 p.m.
at the Cambridge Yacht Club in Cambridge, Maryland

This conference is for members in Worcester, Somerset, Dorchester, Wicomico, Talbot, Caroline, Queen Anne's, Kent, and Cecil counties. Conference topics include current problems in Medicare reimbursement and a legislative update. The meeting will also feature a one-hour continuing medical education presentation on

"Early Diagnosis and Treatment of Lyme Disease"

Speaker:

John G. Bartlett, M.D., chief, Division of Infectious Diseases, the Johns Hopkins Hospital

Objective:

Participating physicians will be able to recognize the early signs of Lyme disease and will be aware of the most efficacious treatments.

CME credit: 1.0*

For more information about this conference, contact Joan Mannion in Med Chi's Continuing Medical Education Department at 410-539-0872 or 1-800-492-1056.

*Third Annual Conference
on Addiction: Physician
Health and Education*

Saturday, November 2, 1992 at the Med Chi Faculty Building,
1211 Cathedral Street, Baltimore, Maryland

This continuing medical education program will educate physicians and other health care practitioners on substance abuse issues that affect their patients, and educate physicians and other health care professionals on issues that affect their own lives. For more information on this program, see the conference schedule and registration form on pages 924-925 of this *MMJ* or contact Vivian Smith at 410-539-0872 or 1-800-492-1056.

*1993 Med Chi Annual
Meeting*

Friday, April 30 and Saturday, May 1, 1993
at the University of Maryland, University College Conference Center
in College Park, Maryland.

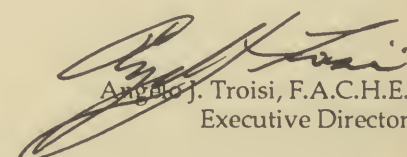
Mark your calendars! The theme for this year's meeting will be "Prevention '93 Maryland." Watch the *Executive Director's Newsletter* for meeting updates.

*Second Annual
Performing Arts
Medicine Conference*

Med Chi's Committee on Medicine and the Performing Arts will present, in March 1993, a second conference on performing arts medicine. As a follow-up to the successful January 1992 conference, this meeting will further explore treatment and prevention of health problems experienced by instrumental musicians, vocalists, and dancers. Watch future issues of *MMJ* for further information.

*The Medical and Chirurgical Faculty of Maryland is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

The Medical and Chirurgical Faculty of Maryland designates this continuing medical education activity for 1 credit hour in Category 1 of the Physician's Recognition Award of the American Medical Association.



Angelo J. Troisi, F.A.C.H.E.
Executive Director



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John Archer, M.B.:

One of the great medical pioneers of this state

John Archer, bachelor of medicine, is on an ethereal plane in Maryland medicine. One of the great medical pioneers of this state, he was the first individual to receive a medical degree from the first medical school in America. He made numerous contributions to medical education and was a major in the militia, a commissioner of peace

In 1889, the medical diploma of Dr. Archer (**Figure**) was presented to the Medical and Chirurgical Faculty of the State of Maryland by Dr. George W. Archer, John Archer's grandson. The certificate is not in good condition, but the important parts of the Latin script are still decipherable. The translated names of the Academy of Philadelphia, John Archer, the degree, and the date (June 21, 1768) are clearly discernible. The signatures of John Morgan, William Shippen, and Thomas Bond may be read easily.

Morgan and Shippen were cofounders of the school in 1765. Morgan had created a plan for a medical school at the request of the trustees of the College of Philadelphia. Instruction over a period of three years eventuated in the graduation of ten men in 1768. Morgan was professor of the theory and practice of medicine, and Shippen was professor of anatomy and surgery. The school later became part of the University of Pennsylvania.

References

1. One of his descendents. A biographical sketch of John Archer, M.B. *Bulletin of the Johns Hopkins Hospital* 1899; X:141-47.
2. Cordell EF. Transactions of the Harford Medical Society. *Bulletin of the Johns Hopkins Hospital* 1902; XIII:181-88.
3. Finney WHM. John Archer: First medical graduate in the New World. *Med Med J* 1990; 39:1089-92

JOSEPH M. MILLER, M. D.
Timonium

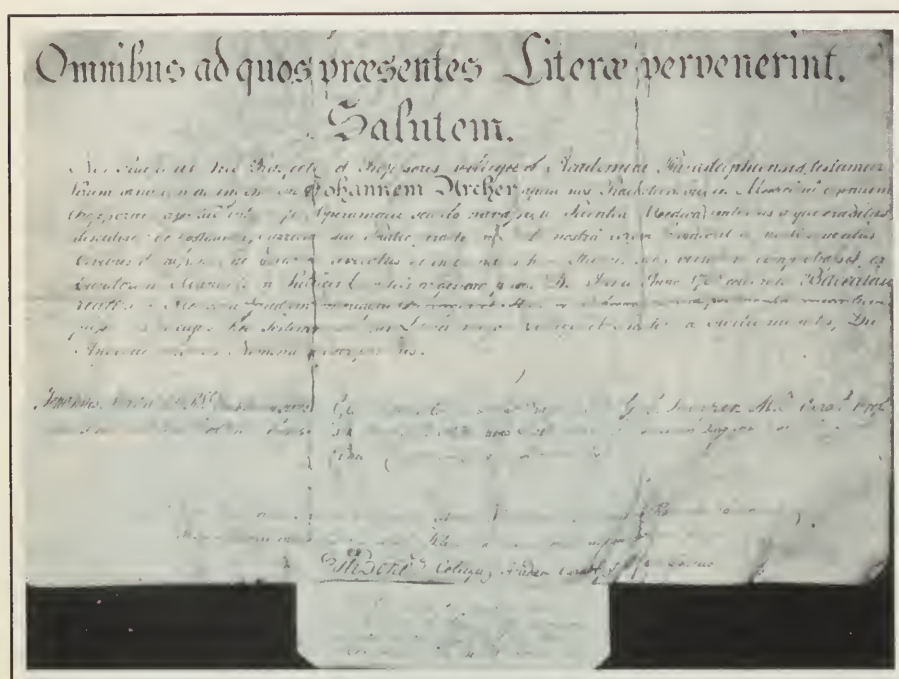


Figure. The medical diploma of John Archer, M.B. was received from the Philadelphia College of Medicine on June 21, 1786. Reproduction of the certificate was possible through the courtesy of the Medical and Chirurgical Faculty of Maryland.

for Harford County, a judge of the orphan's court, an elector to the state senate, and a representative to Congress (1800-1804). Many medical students placed themselves under his tutorage, and for a quarter of a century, about a half-dozen men were usually under his instruction. In 1797-1798, his students formed the first medical society of Harford County.

The hypothesis explored

Sir Arthur Conan Doyle supplemented his ophthalmology practice income by writing detective stories.

Sir Arthur Conan Doyle (May 22, 1859–July 7, 1930) earned his doctorate in medicine at the University of Edinburgh. In 1885, he began an ophthalmology practice at number 2 Devonshire Place, near Harley Street, in London, England. Unfortunately, his practice grew slowly, so he supplemented his meager income by writing detective stories. As his paradigm, he used Joseph Bell, M.D., one of Doyle's finest and most astute professors, who promptly became Sherlock Holmes of 221B Baker Street.

to be remembered—but which have long been virtually forgotten. In addition, he wrote a number of pamphlets supporting England's decision to fight the Boer War, and he was an ardent spiritualist (particularly following his son's death in World War I).

Finally, and more to the present point, he fancied himself an amateur paleontologist. During the period of the Piltdown affair, he lived in Crowborough, England, several short miles from the Piltdown quarries. He knew Dawson, and, in fact, had dined with him on several occasions.

In 1983, writing in the journal *Science*, two American archaeologists hypothesized that Arthur Conan Doyle may have executed this greatest of all scientific shams. (Winslow JH, Meyer A. The Perpetrator at Piltdown. *Science* 1983; 4:32–43.)

But in 1990, Dr. Frank Spencer, professor and chairperson of the Department of Anthropology at Queens College of New York, wrote a text entitled *Piltdown: A Scientific Forgery* (Oxford University Press). In this book he exploded that hypothesis, stating quite clearly, ".....Doyle first learned of the [Piltdown] site's existence in the autumn of 1912, by which time Piltdown was an 'open secret.'"

Donald Johanson wrote *Lucy's Child* before Spencer had published his treatise on Piltdown. Nonetheless, as with other great mysteries, the magnificent hoax will continue to captivate and tantalize—and to serve as the classic model of scientific fraud.

BART GERSHEN, M.D.
Rockville

Was Sir Arthur Conan Doyle the perpetrator of the magnificent hoax?

I read with interest your [Dr. Gershen's] commentary in the recent *Maryland Medical Journal* ["Word Rounds," April 1992]. I noted that you didn't speculate on the perpetrator of "The magnificent hoax."

I recently read *Lucy's Child* and, in that, Donald Johanson tossed out the possibility that the perpetrator might have been Sir Arthur Conan Doyle. Have you ever heard that before from any other source? I would be interested to hear. I enjoyed the article. Thanks for it.

ALBERT J. STRAUSS, JR., M.D.
Hagerstown

Sir Arthur's first novel was *A Study in Scarlet*, published in 1887. In 1890, flushed with financial success, he retired from the practice of medicine to devote all his time to fiction.

In addition to writing mysteries, Sir Arthur wrote science fiction works such as *The Lost World*, which was ultimately made into a popular motion picture. He also authored historical works such as *Micah Clarke* and *The White Company*, for which he fervently wished

Editorial

Uncivil wars

The ancient Romans called it *nex*. Death. It was an unpopular word—yet, strangely, one with many descendants. **Necropsy** and **necrosis** are two offspring. So is the term **internecine**: "A war between rival factions of the same tribe—a conflict within a family—a civil war." In Med Chi, we recently witnessed such an event. ■

We watched an election. One so distorted by anger and suspicion, so besieged by Machiavellian conduct, so engrossed in political stratagem as to have thoroughly perverted the relevance of our gathering.

The integrity of our profession is currently under external siege. Our character and principles, which we have assumed to be a matter of historic record, are no longer taken for granted by a jaded public. Our competence, autonomy, and sovereignty over matters medical are no longer uncontested.

We are considered arrogant, officious, insensitive, and avaricious by a fast-rising current of popular opinion. The federal and state legislatures incessantly erode our dominion over patient management, medical administration, and hospital privileges. Our profession is atrophying, and we are being devoured by ravenous bureaucratic harpies.

The irony is that we respond to these charges by tearing at each other like a pair of Kilkenny cats.

Frankly, I do not care who wins or loses our elections. I care only that this society is governed by honorable men and women who respect the will of the Council and House of Delegates and who can properly and aggressively defend the standards, the virtue, and the excellence of our profession.

We are a unique species in imminent danger of extinction. There is no room here for pettiness, envy, paranoia, or self-aggrandizement.

It is time to renew our professional covenant with one another.

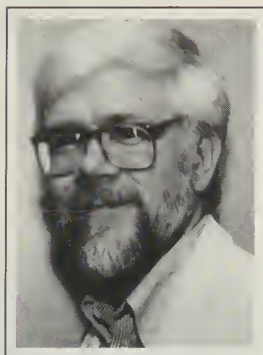
It is time to stand together.

It is time to end our uncivil war.

BARTON J. GERSHEN, M.D.

Rockville ■

MEMBERS IN THE NEWS MEMBERS IN THE NEWS MEMBERS IN THE NEWS



Theodore Harrison, M.D., an emergency room physician at Carroll County General Hospital, has been elected to a second two-year term as president of the Maryland Chapter of the College of Emergency Room Physicians. Dr. Harrison, who received his bachelor's degree and medical degree from the Washington University of St. Louis, served

his internship at the University of Southern California Medical Center and completed residency training at Johns Hopkins Hospital. A resident of Millersville, he is board certified in emergency medicine. The College of Emergency Physicians, which represents over 220 doctors in Maryland, is a professional association dedicated to the continuing education and training of its members and to increasing public awareness about this medical specialty. Dr. Harrison, who has held a number of offices in the Maryland Chapter, has been active in the organization for more than ten years.



H. Alexander Munitz, M.D. was recently named chairperson of the Department of Radiology at the Greater Baltimore Medical Center and was elected president of



LaSalle Diagnostic Imaging. Dr. Munitz received his medical training in South Africa, where he completed internships in medicine, surgery, and pediatrics. During two years of service in the South African Army Medical Corps, he received a diploma in aviation

medicine. He was also extensively involved in the medical care of children with severe malnutrition, tuberculosis, rheumatic fever, and gastroenteritis in a primitive area of rural South Africa. Following his army service, Dr. Munitz came to the United States to begin a residency program in radiology at Bowman Gray School of Medicine in Winston-Salem, North Carolina, where he also completed a fellowship in abdominal imaging. He then joined the school's radiology faculty, specializing in gastrointestinal imaging and interventional uro-radiology. In 1986, he came to Baltimore where he began concentrating on his current specialty areas: mammography, gastrointestinal radiology, and magnetic resonance imaging. He has published extensively and is a member of numerous professional organizations.

Thomas J. Oglesby, M.D. was recently appointed chief medical officer of the Circuit Court for Baltimore City. Born in Brooklyn, New York, he came to Baltimore in 1975 after completing his psychiatric residency at the



University of Utah. Since that time, he has combined a full-time private practice in psychiatry with forensic consultations, and was appointed assistant chief medical officer of the Circuit Court for Baltimore City in 1990. Dr. Oglesby is an assistant clinical professor of psychiatry at the University of Maryland Medical School; is chairperson of

the Department of Psychiatry at Mercy Hospital; and is on the staff of the Greater Baltimore Medical Center, St. Joseph's Hospital, and Union Memorial Hospital. He resides in Baltimore with his wife, Ann, and their four children.



Henry N. Wagner, M.D., professor of medicine and radiology at the Johns Hopkins School of Medicine and professor of environmental health sciences at the Johns Hopkins School of Hygiene and Public Health, was recently



selected as the 1992 recipient of the NEMA (National Electrical Manufacturers Association) Medical Technology Leadership Award. NEMA's Diagnostic Imaging and Therapy Systems Division sponsors this award to recognize outstanding contributions to industry in the areas of product safety, tech-

nological innovation, and government relations. Dr. Wagner, director of the Division of Nuclear Medicine and Radiation Health Sciences at the Johns Hopkins University, is one of the most widely recognized figures in the field of nuclear imaging today. He has made significant contributions in the development of new imaging agents and innovative instrumentation. A fellow of the American College of Physicians, Dr. Wagner had been the recipient of numerous awards throughout his career, including the AMA's Scientific Achievement Award and the Society of Nuclear Medicine's Hevesy Award. ■

Star Wars

The Latin for speaking is *fans*. A small human who had not yet spoken came to be called an **infant** (*in* 'not' + *fans* 'speaking'). The original meaning was soon expanded to include young people, whether they could actually speak or not. Thus the female heir to the Spanish throne was referred to as the *infanta*.

In the Middle Ages, a noble French lad who had not reached knighthood was called an *enfant*. In Italy, he was known as an *infante* and walked behind his knight's intrepid steed, carrying the warrior's armor. An entire garrison of these children were known as an *infanteria*. Thus was born the foot soldier—the dogs of war—the **infantry**. Possibly the ineffable tragedies they witnessed had rendered them speechless. War does that sometimes.

On the other hand, war may cause us to fabricate new expressions to create its own distinctive jargon. For example, there were the Parthians who from 247 BC to 224 AD ruled the region that we call Iran. One of their great kings was Mithridates, who commanded a superb army. In battle, his cavalry would often appear to be routed. They would retreat, but as the enemy pressed forward, the Parthians turned in their saddles and fired their arrows, killing or wounding many bewildered opponents. This was known as a **Parthian shot**—and over years of lexical evolution, it has resulted in a **parting shot**.

Mithridates himself has earned a meager place in our lexicon. He had deposed his distinguished mother and was a most unpopular monarch, even within the royal palace. Fearing for his life, he began consuming small amounts of various poisons in the belief that he could build tolerance to their lethal effects. After an unsuccessful war against the Roman legions and a triumphant revolt by his troops, he attempted suicide—but the poison failed to work. The king was "hoist by his own petard." He was subsequently impaled on a sword by one of his loyal disciples. (The technique of inducing tolerance to poison by administering small and gradually increasing amounts of the substance is now called **mithridatism**.)

Hoist by one's own petard refers to the **petard**, an explosive cone-shaped apparatus filled with gunpowder and lit by a fuse. In ancient warfare it was used to blast a hole in a defensive wall or to demolish the gates to a castle. Unfortunately, the infantryman whose job it was to plant the bomb often became part of the eruption. Quality control was not as extraordinary as it is today (See "Space Shuttle—O Rings"). Incidentally, the name **petard** derives from French *peter* 'to fart'. It undoubtedly suggested the sound of the explosion—although some etymologists believe it referred to the commanding officer who ordered the maneuver.

The **musket** was an early firearm that evolved in Spain during the 1500s. It was a smooth bore, shoulder-fired weapon. To load the gun, a soldier first poured gunpowder into the muzzle, followed by a two-ounce steel ball. In the earliest models, powder was ignited by lighting a match and holding it to the gunpowder pan. These were known as **matchlock rifles**. They were superseded by the more sophisticated **flintlock rifle** invented in seventeenth-

century France. A spring-loaded hammer or striker was connected to a trigger. On squeezing the trigger, the hammer was released, striking a piece of flint and showing the gunpowder with sparks, resulting in the requisite explosion needed to propel the metal ball. Occasionally, the trigger mechanism failed, releasing the hammer too soon. This caused the gun to **go off half-cocked**. Moreover, if one were to accidentally moisten the gunpowder (as could occur during a heavy rainstorm), the gun might not fire at all. This resulted in the well-known admonition to **keep your powder dry**. Furthermore, there were occasions when the powder would ignite but then fizzle out without firing the shot. This was known as a **flash in the pan**.

The Dutch expanded the distal end of the musket, filling it with several smaller balls. When the gun fired, the shot scattered widely over a very short distance—the first shotgun. They called it a **donderbus** (*donder* ‘thunder’ + *bus* ‘gun’). The accuracy of this weapon was laughable, thus prompting the British to deride it as a **blunderbuss**.

Our Civil War enlarged the language, even as it diminished the population that spoke it. The first American **Admiral**, David Farragut, was commissioned in 1866. (From the Arabic *Amir a’Ali* ‘high leader’.) Other familiar military terms such as **AWOL**, **drafter**, **ensign**, **pup tent**, and **war correspondent** were born. The famous **Springfield rifle** was developed and built in Springfield, Massachusetts, and the equally renowned **Sharps’ rifle** was designed by Christian Sharps. The men who used it proficiently came to be called **sharpshooters**.

World War One (WWI) further expanded our combat patois, adding much bureaucratized and military gibberish. **U-boats** sank the *Lusitania* (German *unterseeboot* ‘under-sea boat’ or u-boat for short), and **Big Bertha** shelled Paris in 1918, from 75 miles away. (Big Bertha was the mocking and derisive name applied to a giant cannon manufactured by the famous Krupp steel works, the owner of which was a rather corpulent German dowager—Frau Bertha Krupp von Bohlen und Halback.)

We developed all sorts of interesting names to call the Germans and their army: **Hun** (modeled after Attila himself), **Boche** (French contraction of *allemond* + *caboche*—*alboche* ‘German cabbagehead’, further shortened to Boche), **Heine** (short for Heinrich, a common German name), **Fritz** (scornful nickname for Friedreich, another

common German name that was incorporated into a disdainful expression of incompetence—to **be on the fritz**), **Jerry** (German helmets resembled chamber pots which, in England, were known as jerries), and **Kraut** (short for sauerkraut or soured, chopped cabbage—a German dietary staple).

The British soldiers were known as **Tommies**. This evolved from a sample English recruiting form in which the applicant was named “Tommy Atkins,” synonymous with our “John Doe.” The Brits were also known as **limeys**—from the early practice of feeding English sailors lime juice as an antiscorbutic on long ocean voyages. (Latin *scorbutus* ‘to wither and grow ill’). In 1754, Dr. James Lind, a British naval surgeon, published *A Treatise On Scurvy* in which he recognized the value of citrus fruit in the prevention of the disease. At the time, more sailors were dying of scurvy than were being killed in combat. However, it wasn’t until 1795 that the Royal Navy ordered lemon or lime juice for all ships of the fleet. Scurvy disappeared abruptly, and British sailors have been **limeys** ever since.)

Doughboys, as our soldiers were called, stemmed from the large buttons adorning their uniforms which resembled dumplings or fried sweet corn cakes of the same name. The soldiers were also known as **Joes** (a generic American nickname), and since they were government issue—**GI Joes**, and then simply, **GIs**. They wore metal identification tags around their necks, resembling dog licenses hanging from a collar—hence **dogtags**.

Khaki uniforms became standard during WWI (Hindi *khaki* ‘dust covered’). The men dug long, deep ditches that were called **trenches**, from which arose such famous expressions as **trench knife** and **trench coat**, as well as several diseases including **trench foot**, **trench mouth**, and **trench fever**.

But the true mercenary in this global conflict was a respiratory virus—**influenza**. Emerging from Spain in 1918, it swept the world, becoming a true **pandemic** (Latin *pan* ‘all’ + *demos* ‘people’). The first outbreaks occurred thousands of miles apart—Boston, Massachusetts; Brest, France; and Freetown, Sierra Leone. At Camp Devens in Massachusetts, the first case occurred on September 12, 1918. Eleven days later, 12,604 men had become gravely ill. In contrast to most influenza epidemics, this one killed young as well as old. Within the camp morgue, bodies

"the color of slate" were stacked like cordwood. The lungs filled rapidly with a thin, bloody exudate. Eyewitnesses described young men who turned blue before them and died in less than 48 hours. Colonel William Henry Welch, a pathologist who had been the first dean of Johns Hopkins Medical School (1893–1898) and who had discovered the gas gangrene bacillus, was sent to Camp Devens to direct medical operations. There was very little he could do to stem the plague.

When it was over, 675,000 Americans—including 24,000 soldiers—were dead. Worldwide totals have been estimated at 22 million deaths, although that figure is surely conservative. (India alone had 12 million dead, with estimates of as high as 30–40 million.)

Our total battle deaths in WWI were 53,513.

The name **influenza** originates directly from Italian *influenza* 'influence'. It was a disease that the ancients believed was entirely under the influence of the stars.

Perhaps they were correct. ■

The University of Maryland will play a two-part satellite broadcast,

"Information STAT: Rx for Hospital Quality,"

On October 22 and November 5, 1992.

The program, which will assess the critical role information services can play in improving hospital quality and cost-effectiveness, is sponsored in part by the National Library of Medicine and the Medical Library Association. Members of the Maryland Association of Health Sciences Libraries, their administrators, supervisors, and library committee chairpersons, as well as university personnel, are invited to the viewing.

For more information about the broadcast,
contact Susan Bailey at 1-800-338-7657.

The Guide to Living with HIV Infection. John G. Bartlett, M.D. and Ann K. Finkbeiner. Baltimore: The Johns Hopkins University Press. 1991. 337 pages. \$15.95.

"Everything you wanted to know about AIDS (acquired immunodeficiency syndrome) and were afraid to ask" adequately describe this book by Dr. John G. Bartlett and Ann K. Finkbeiner. Inasmuch as treatment at the moment bespeaks only to delaying action in the course of the disease, the authors propose a plan for living through difficult times for the infected individual and his or her caretakers. Viewed from the aspect of the epidemic infections that have ravaged the population of the earth since the beginning of recorded medicine, AIDS casts the shadow of a great public disaster. Cure by means of medication or the use of a vaccine has not yet been achieved despite intensive study, as alleviation only is obtained from the use of zidovudine (AZT). The chilling possibility exists that about 500,000 Americans will be infected by 1993.

In the absence of specific therapy, the threat of death to the sick individual is real, and the psychogenic effects upon the patient and his or her relatives are frightening. Some alternative help must be given to these people until a curative method of treatment is found.

A number of books about AIDS have been published, but none has approached the problems of these afflicted humans with the knowledge and delicacy of feeling expressed by the authors of this book. This medically reliable manual covers all aspects of the disease and its complications to provide a plan to help AIDS patients with their physical and mental difficulties. Knowing the eventual prognosis, the patients must be supported by compassionate care and understanding.

While efforts are being made to find a satisfactory medication, infected individuals must exert care not to give the virus to others. AIDS is transmitted, for the most part, by unsafe sex practices and the intravenous administration of illegal drugs through contaminated needles. The virus may also be passed from a mother to her unborn child, although how transmission occurs is unclear.

The book gives patients simple, clearly stated directions, telling them how to prevent transmission of the disease to others, as patients must acknowledge that they are the carriers by whom other people are infected. Patients are informed that they must have safe sex and must sterilize needles for intravenous use, and that pregnancy and breastfeeding should be avoided. Precautions incident to the use of contraceptive devices are explained clearly.

Of the estimated 1 to 1.1 million Americans harboring the AIDS virus, 800,000 were infected from genital secretions, and 235,000 from drug use. Instances of infection

from blood transfusion (40,000) and the use of blood products in hemophilia (10,000) have now been stopped by treatment of blood or its products before its therapeutic administration.

The book addresses related financial and legal concerns in an authoritative fashion. Patients with AIDS are protected under the Rehabilitation Act of 1973 against discrimination by handicap, which in this instance is the disease. In addition, the Americans with Disabilities Act of 1990 affords federal protection against discrimination for all people with the immunodeficiency virus. Not well recognized at the moment, however, are the moral and possibly legal obligations of the infected patient to notify anyone at risk, which includes sex partners and drug users with whom needles have been shared.

In short, this book about AIDS details the causes, means of transmission, and cost to the patient, relatives, and general public. The total problem is mind-boggling, and the steady, unhalted progress of the disease all over the world makes finding a satisfactory solution a matter of first priority.

The time may come when the number of infected people is so great that provision of care may be utterly impossible. In addition, the number of hospitals and trained caretakers necessary would put a tremendous economic strain on this country.

The first symptoms of human immunodeficiency virus (HIV) infection occur early in the disease process, with a latent period of two to six weeks after acquiring the virus. About 50–90 percent of individuals have acute symptoms that resemble those of many common viral infections. Seroconversion or the recognition of the presence of the disease by the host by means of antibodies may take six to twelve weeks.

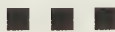
For unknown reasons, patients are then asymptomatic for periods of five to eight years and, unless a blood test is done during this period, the individual will be unaware that infection is present. About 70–80 percent of people with HIV are in this classification, and this pool constitutes a great threat for spread of the virus.

Although anti-discrimination laws exist to protect AIDS patients, the reviewer believes the problem of the spread of infection may yet make the use of quarantine and isolation inevitable. If AIDS patients persist in their present practices, some further method of control may be required. In past centuries, isolation was used to control infectious diseases through the use of pest houses and lazarettos, which were common in the Middle Ages to prevent the devastation of the plague. One hopes that the discovery of effective medication will prevent the occurrence of such an event. How to enforce the suggestions made to patients to stop the spread of AIDS is a frequently asked question, but it does not have a satisfactory answer. The prospect of more than a million Americans, by 1993,

in the various stages of AIDS is frightening. The War on Cancer of 1970 sputtered to a halt without a good result, but perhaps a better solution will be obtained in the fight against AIDS. Only informed people may react positively, and this manual makes long strides toward fulfilling that purpose. This book should be read by anyone over the age of 12 and, in fact, may do more good for uninfected people than those harboring the virus. The healthy part of the population cannot be passive bystanders but must be alerted to the use of protective steps to prevent their own infection.

JOSEPH M. MILLER, M.D.

Timonium



The President Has Been Shot. Herbert L. Abrams.
New York: W.W. Norton and Company. 1992. 363
pages. \$22.95.

The title of this interesting book might better have been "A Critical Examination of the Twenty-Fifth Amendment" (the Twenty-Fifth Amendment is concerned with presidential succession). During a period of a little over 200 years, eight of the past forty US presidents either died from natural causes or were assassinated while in office. Their vice-presidents had a 20 percent chance of succeeding them. Of equal importance and demanding clearer resolution is the problem posed by an injured or seriously ill president, incapable of fulfilling the duties of the office. If the president is not cognizant of the incapacity or refuses to acknowledge it, the vice-president and the major supporting officers of the chief executive might declare the president's incompetency during the period of time involved.

During the two months after Garfield was wounded and the year-and-one-half during which Wilson was incompetent, their vice-presidents lacked the clear ability to declare the presidents disabled. If the vice-presidents had ousted their presidents, a politically explosive incident would have been occasioned. During the Wilson period of stress, Mrs. Edith B. Wilson or Dr. Gary Grayson (physician to the president) served as "acting president." The reins of government fell into their hands, and Grayson orchestrated the cover-up of the actual clinical condition of Wilson in the hope of ameliorating Wilson's emotional problems. Situations such as this one are the *raison d'être* of this book.

The Constitutional provision of 1787 states that "inability to govern" by the chief executive may be a reason for the vice-president to become the "acting president," but the method to accomplish this provision was not carefully detailed. The twentieth amendment (1933) provided only

for the vice-president to become president if the president-elect died before the time of the inauguration. In 1967, the Twenty-Fifth Amendment addressed a number of important points: it delineated the line of succession if the vice-president died or resigned; it provided that the president could appoint a vice-president if a vacancy occurred in that office; and, more importantly, it added two other provisions. If the president believed that s(he) would be unable to perform capably for a period, the president could notify the president pro tempore of the Senate and the Speaker of the House of Representatives by letters that the position would be relinquished until such time as the president had recovered, when the notification process would be by the same method. In addition, if the vice-president and a majority of the principal officers of the executive departments believed that the president was not capable, they could, in a similar manner, petition the two houses of Congress to recognize the vice-president as the "acting president." The line of succession through the Speaker of the House, the president pro tempore of the Senate, and the various cabinet offices in the order of their creation was delineated. Should the president believe that s(he) is capable but his or her advisers think differently, the problem would be resolved by Congress.

In 1981, when Reagan was shot, the first opportunity to exercise the Amendment arose. Bush took extra care to disclaim any new authority, and the remainder of the individuals in the White House failed to exercise good judgment. During the first few days of the incident, the best purposes of the country were not served by their refusal to invoke the transfer of power by the Amendment concerned. Nevertheless, when Reagan had a right colon resection in 1985 for carcinoma, he turned over the duties and powers of the presidential office to Bush.

A more recent episode was encountered when cardioversion under anesthesia became a possibility for Bush. To his credit, he made the necessary preparation to enable Quayle to be the "acting president," but, fortunately, Bush's cardiac arrhythmia responded to drug therapy.

In any period of presidential disability, the physician-in-charge must provide the public with essential information. Admittedly, communication between the president and the president's doctor is confidential, but such information is difficult to separate from responsibility to the nation. Many physicians at the White House have been selected for other qualities than their medical knowledge. The use of competent physicians who could, in an emergency, declare the president incapable of performing presidential duties might be a step in the right direction. Such a protocol would clear the parallel responsibilities of the doctor to the patient and to the nation.

A detailed account of the attempted assassination of Reagan opens the book and serves as the focus of discus-

sion for the apparent non-use of a plan created for just such an emergency. Certainly, Reagan could not be expected to function in the manner demanded by the office at the time of the shooting, during the operation, or for the first few postoperative days.

Easily read, the book will relate or refresh a number of historical facts and, perhaps, teach a little government. Readers will conjecture why the Amendment was not used and will realize that the best interests of the public were thwarted by the refusal of then Vice-President Bush and the people around the president to intervene.

JOSEPH M. MILLER, M.D.
Timonium ■



The 36-Hour Day. (Revised Edition). Nancy L. Mace, M.A. and Peter V. Rabin, M.D., M.P.H. Baltimore: The Johns Hopkins University Press. 1991. 329 pages. \$10.00.

The *36-Hour Day* has become a classic since the first edition (1981). The second edition (1991) includes many updates, and it is written with a gentler tone. The format is unchanged. The content is a complete do-it-yourself manual for the day-to-day management of a demented person.

As a manual, it does not offer a happy ending. The completion of the project is death. Like other good manuals, it is clear, concise, comprehensive, well organized, and well indexed. Reading between the lines, you can easily

imagine the scope of the project. When you see an Alzheimer's victim in your office, there is a brief glimpse of the wearing responsibility and patience required for the individual's care. The discussions in *The 36-Hour Day* are practical and nonjudgmental. Just reading a particular section may be soothing to the caregiver.

The scope of the book is wide. Topics range from the management of wandering to the impact of dementia on teenagers in the home to research in brain disorders to self-help groups.

As a classic, *The 36-Hour Day* should be read by all physicians and medical students and should be kept as a reference in all medical offices. Even pediatricians will encounter dementia and the impact that its care may have upon family members.

Although the text is quite readable, it can be discouraging if read all at once. Like some required reading in school, this book is best appreciated if undertaken a chapter at a time (there are eighteen chapters). The catchy title does not make this book light summer reading. Do not take it to the beach for a literary escape.

The new 329-page edition from Hopkins Press is pleasantly designed with bold headings, but print that is none too big. At \$10.00, the blue-covered, six-inch by nine-inch paperback is a bargain, and you should consider buying a few copies. Occasionally a family will be so distraught that a trip to a bookstore may be too much to expect. The family will be eternally grateful for the loan or gift of *The 36-Hour Day*.

JOHN W. BUCKLEY, M.D.
Towson ■

Dr. Robert C. Thompson: Pilot

THERE'S A BIRD! THERE'S A PLANE! THERE'S A DOCTOR? Dr. Robert C. Thompson, a member of the Medical and Chirurgical Faculty of Maryland, is one physician whom you might find in the cockpit of a plane (Figure 1).

Dr. Thompson, an orthopaedic surgeon in Easton, Maryland, is a pilot, a flight instructor, and an aerobatic flying student. He traces his interest in flying

rating and commercial license, and then went on to become a flight instructor.

Dr. Thompson calls his personal plane, a Cherokee Six 300, "Betsy the Buzzard," but offers that he means it as an endearing name (Figure 2). He often explains things in farming metaphors and compares his plane to a good farm animal, declaring that he prefers a "good team of mules to a horse any day."

As a member of the Flying Physicians Association (FPA), Dr. Thompson shares his joint love of flying and medicine with aviation medical examiners (AMEs), neurologists, plastic surgeons, and ophthalmologists, among others. Members of FPA must hold both a medical license and a pilot's license.

Along with his wife Patricia, a registered nurse and faithful traveling companion, Dr. Thompson attends FPA meetings, visits friends across the country, and takes day trips. "We can fly anywhere for lunch. We fly to Martha's Vineyard for the day and think nothing of it."

Although his fascination with flying is an obvious one, he quickly admits that medicine is his first love. On the ground, Dr. Thompson is in private practice and has been for the past eighteen years. He also enjoys privileges at Memorial Hospital in Easton and Dorchester General Hospital in Cambridge.

He never intended to become a physician, although his father was an orthopaedic surgeon. Dr. Thompson was interested in electrical engineering as it applied to biology and planned to become a neurophysiologist. But his college guidance counselor convinced him that "a career in neurophysiology would be as well served with an M.D. degree as it would with a Ph.D., and if I ever wanted to do science—neuro-



Figure 1.
Dr. Thompson
with his wife
Patricia.

to his childhood. He recalls, at about age six, spending time with a cousin in Norfolk, Virginia who was making models to be used in wind tunnels to test the airplanes being built for World War II. Dr. Thompson was fascinated with planes, but knew he could not afford flying lessons.

He never let go of his desire to fly, and, in 1984, he hired a flight instructor. In May of that year, although he had never set foot in a plane before, Dr. Thompson put in 33.5 hours of flying time in the first eight days. After about 48 hours of flying, he took his pilot's test. Later he received his instrument

Figure 2. "Betsy the Buzzard," Dr. Thompson's personal plane.



logical science on people—I'd have to have an M.D."

While looking for electrical activity in the bone, he became more fascinated with the way the bone behaved and more interested in setting the bone, and less interested in the electrical activity of the bone. Ultimately, he ended up as an orthopaedic surgeon.

Dr. Thompson went to medical school at Johns Hopkins University, completed internships and residencies

ple—"they don't live in fantasies or artificially designed market structures."

Admitting he is not in the political arena at all, Dr. Thompson finds that "in terms of what it really means to be a physician—apart from just having obtained your doctorate degree in medicine—is caring for people and caring for the ill."

But as a physician, Dr. Thompson has learned that medicine isn't always as simple as giving a prescription or even performing an operation. "The one who really has something left to give when there is no medicine to give—I think that's the ultimate."

Nonetheless, as a surgeon, he realizes there will come a time when it will no longer be safe for him to practice medicine. But rather than lament the loss of a career, he excitedly explains, "I've already started to work on developing a flight school, so what I'll do is phase out of the surgical side and phase in the flight training side."

But even becoming a flight instructor isn't his last new frontier. Creating another challenge for himself, Dr. Thompson recently became an aerobatic flying student. He believes he will be at ease performing stunts in planes, because as a late teen he was an exhibition diver who "did wild stuff." Familiar with the plane and familiar with the various gyrations of stunt performers, Dr. Thompson believes that aerobatic flying was the natural next step. He and his wife attended judging school last summer to become aerobatic flying contest judges and recently acted as assistant judges for the first time.

Dr. Thompson admittedly is a "person who always has four things going." All through his life, he made the stresses of being in the medical profession more manageable through outside interests. He has sung baritone in a barbershop quartet for the past fifteen years and has written modern jazz vocal

in Baltimore, and worked in the metropolitan area for about two years before moving to Easton.

As a physician in a rural community, Dr. Thompson finds his patients are more "acquainted with the realities of life" than suburban people. He explains that they understand life and death from raising farm animals, not from watching television.

He likes the fact that he can publish his home phone number in the local directory and know that no one will take advantage of it. "You can't be anonymous. You walk down the street and one person in three knows exactly who you are—calls you by name. You know them."

Dr. Thompson believes some physicians probably go to the cities to avoid just that sort of recognition but admits he likes being "just one of the guys and part of the community." He likes the people and refers to them as real peo-

When the Doctor is Out

This month, the *Maryland Medical Journal* initiates a new column focusing on Med Chi members who, in addition to practicing medicine, have novel hobbies, unconventional interests, or other occupations. If you fit in this category or know of a colleague whom we should feature, please contact Vivian Smith, Public Relations Director, at 410-539-0872 or 1-800-492-1056

arrangements. He also enjoys charcoal sketching.

Besides the arts, Dr. Thompson has an interest in computers. He worked his way through medical school as a free lance computer programmer conducting statistical analyses for researchers at Johns Hopkins. He now serves as a professional computer programmer for the Med Chi Auxiliary.

His computer abilities have carried into his medical profession as well as his flight instruction, and he spends an hour or two a day trying various programs.

He beams, "Everything I'm doing is so exciting to me."

Vivian Smith

Ms. Smith is Public Relations Director, Med Chi. ■

Approximately 1,000 physician pilots belong to the Flying Physicians Association (FPA). Members share flying, educational, and social activities.

In 1955, the FPA was organized with the basic goal of promoting safe flying. Now the association's program includes the following:

- Promoting education and research related to medicine and aviation
- Stimulating the acceptance of aviation medicine in young men and women programs on aviation safety and aviation medicine, as well as medical issues outside their field of practice. During the rest of the year, members may participate in the activities offered by one of five regional chapters: Western, Dixie, Great Lakes, Northeast, and Southwest. Developing and maintaining a system for rapid movement of trained medical personnel and emergency supplies to any area of disaster
- Promoting aviation safety by research, education, and dissemination of medical factors affecting the operation of aircraft Encouraging aviation activity among physicians for the betterment of the medical profession
- Emphasizing the use of aircraft in facilitating the practice of medicine
- Cooperating with civilian agencies engaged in the welfare of our country

The FPA holds its annual convention between June and September each year. Continuing medical education credits are offered to physicians for

In addition to the annual and regional meetings, the physicians participate in fly-ins to places such as Alaska, the Caribbean, Mexico, and Canada. Winter meetings are also held in places as diverse as Sun Valley, Snowmass, and Europe.

For further information, call or write to

Flying Physicians Association
Box 17841
Kansas City, MO 64134
(816) 763-9336

On Deaning And Hopkins: An interview with Richard S. Ross, M.D., dean emeritus of the Johns Hopkins University School of Medicine.

Janet Farrar Worthington

Mrs. Worthington is editor of Hopkins Medical News.

Dr. Ross served as dean from 1975 to 1990. In June 1991, Hopkins dedicated its major new medical research building in his name.

Richard S. Ross, M.D. tells a story that was told to him in 1975, when he became dean of the Johns Hopkins School of Medicine, and the average tenure for deans was three or four years—A departing dean left three envelopes for his successor, each containing advice for coping with calamity. The new dean tore open the first envelope during a financial crisis and found this message: "Blame it on your predecessor." The strategy worked, and all was quiet for a year or so. The next envelope, opened during a much-publicized faculty scandal, said: "Form a blue-ribbon committee to investigate." This, too, was successful. The third message, however, was brutally short: "Prepare three envelopes."

Dick Ross has thought a lot about deaning during his four decades at Johns Hopkins and his fifteen-year deanship, the second-longest in Hopkins' 100-year history. He believes success lies in maintaining common sense, keeping in mind the big picture or the long-range view, and in balancing teaching, research, and patient care.

On changing medical education

On the subject of medical education, Ross' philosophy is simple: "Select the best possible students, bright, well-rounded, motivated, imaginative people. Put them together with good faculty who enjoy teaching, and provide good facilities. Then leave it alone. Just let the process work. That's worked for 100 years." However, he adds, medicine is changing. "Hospitalized patients come and go quickly, with illnesses that often are so severe that they're not the best subjects for teaching. The hospital may not be the best or only place to teach medicine anymore. Clinical decisions are made outside the hospital, and there needs to be a way of getting patients and students together when the patient is first coming in contact with the health care system," in an ambulatory setting such as a doctor's office.

Another quandary occurs during the preclinical years. "The mass of biomedical science has tempted us to try to teach the student everything there is to know in lectures," Ross says. "This, too, is not ideal; we're working on it." A related issue, he adds, is preparing students for prob-

lems that may not surface until after graduation: alcoholism and substance abuse, medical economics, and ethical dilemmas.

On new blood and scientific discovery

Ross says he has enjoyed "selling Johns Hopkins medicine" around the country, and visiting with alumni and colleagues at other institutions. "There are other institutions that may be as strong in research, or in another aspect, but Hopkins has it all together across the board. It's a good product, and I'm very proud to be the representative responsible for telling people about it." In his role as salesman, Ross has been highly effective. Several years ago, he began a school of medicine fund to provide start-up support for young doctors trying to launch their research careers—"priming the pump" for a new generation of investigators able to compete successfully for outside research grants. Last year, he allowed colleagues and friends to use his name to raise more money for this fund for future clinician scientists. So far, the Richard Ross Fund for the Clinician Scientist has raised \$6.7 million.

His successor, Michael M.E. Johns, M.D., kids Ross for being too effective as a dean. "Under his leadership, Hopkins moved from seventh place to a consistent second place in winning grant awards from the National Institutes of Health (NIH)," Johns says. "This brought us to a crisis. We became victims of our own success." The mammoth Hopkins research enterprise had grown so much that it ran out of space. "We were turning away grants because we could not house the research operation," Johns continues. "Our scientists were setting up lab benches in the hallways and renovated lavatories." Indeed, the school of medicine's Office of Research and Sponsored Projects ruled that no research proposal could leave the institution unless scientists could guarantee they had space for the project. "Hopkins had two choices," Johns says bluntly: "Freeze faculty hiring, which effectively would prevent the school from attracting new talent, or build new research facilities. Dr. Ross knew that if Hopkins was to maintain its position in attracting and keeping the world's best scientists, it had to be able to offer them excellent research facilities."

New blood, Ross has said, is vital to the future of scientific discovery. It is particularly crucial to Hopkins, with its medical heritage firmly grounded in research. "For Hopkins to move into its second century leaving behind the mission of its founding fathers was out of the question. Clearly, a new research building was critical."

Ross and Johns were among those who gathered June 7, 1991 to celebrate the opening of the new Richard Starr Ross Research Building. In one fell swoop, the ten-story, \$98-million medical research facility increased research space by more than a third—each floor houses twenty-two state-of-the-art laboratory suites, adding 350,000 square feet of research space for use by most of the clinical departments at Hopkins. The building, connected by bridges to a basic science research building and to the hospital, symbolizes what Ross calls "the essence of Hopkins tradition"—the move from the laboratory to the patient's bedside.

"One example of the way space attracts funding," says Johns, "is the recent designation by the NIH of the Johns Hopkins Children's Center as a Child Health Research Center," one of seven in the country. "Two million dollars in pediatric research funds will come over the next five years to support young clinician scientists who will use designated laboratory space in the Ross Building. With the research training they receive, young scientists then can use the tools of molecular biology and genetics to benefit their patients in the hospital."

Richard S. Ross, M.D.,— dean emeritus of the Johns Hopkins University School of Medicine: An interview with *MMJ*'s editor

Betsy Newman

*Ms. Newman is Communications
Director of the Medical and
Chirurgical Faculty of Maryland.*

*MMJ Editor Victor H. Hrehorovich,
M.D. met recently with Richard S. Ross,
M.D., dean emeritus of the Johns Hop-
kins University School of Medicine, to
reflect upon his accomplishments during
his fifteen-year tenure as dean and to
discuss his hopes for the future of the
medical school.*

Dr. H: It is the hope of the Editorial Board of the *Maryland Medical Journal* that three hundred years from now, the *MMJ* will be a valuable resource. It is with this sense of historical mission and responsibility that we approach you on this occasion—to get your thoughts on what it means to have been a dean of a leading medical school during a time of great change in medicine. How did you first become interested in the position?

Dr. R: I never thought about becoming dean. It never occurred to me that this might be something I would do. I was very happy teaching cardiology and conducting research. I had a wonderful group of associates. We were in on the beginnings of a new era in cardiology...performing the first coronary arteriograms at Hopkins and beginning to apply these techniques to understanding various kinds of congenital and acquired heart disease. It doesn't sound very exciting now, but it was in 1960. I was quite happy.

Then I gradually became active in a number of national organizations. I became president of the American Heart Association, and I became more involved with the National Institutes of Health (NIH). I could see that I was slowly getting out of cardiology research and teaching, and administration seemed like a reasonable next step.

I received offers for a number of posi-

At the dedication, Ross said, "It is our strong belief that research is not the province of basic scientists alone. Physicians and surgeons responsible for the care of patients should also be involved in research. I speak with feeling on this issue, because my own modest research career was of this sort, back in the days when I directed the Division of Cardiology. As we cared for patients, we identified problems, and designed experiments to learn more about the patient's disease. In those days, the research was carried out with simple tools and usually in the course of a diagnostic or therapeutic procedure. Things are much more complicated now. The clinical investigator must have training in molecular biology and other basic biological sciences. The principles are the same: The problem is seen in the patient, the answer is sought in the laboratory, and the solution is returned to the patient."

The Ross deanship: A few highlights

There have been other high-water marks during the Ross deanship. To encourage the application of well-rounded medical students, he dropped the medical college admissions test (MCAT) requirement of the admissions process, and approved a Flex-Med program, which allows such options as a year of foreign study before entering medical school. He worked to expand the enrollment of minority medical students, and helped defeat the federal government's attempt to force US medical schools to admit foreign-trained, underqualified American students for their last two years of training. He joined with the Johns Hopkins Hospital in the creation of major construction projects, including the Hunterian Research Building, the Asthma and Allergy Center, and the Outpatient Center, due to be finished in 1992.

The author of more than 150 scientific articles on cardiovascular physiology and disease, Ross has turned down appointments in government to stay in teaching and research. He has been president of the American Heart Association and an editor of modern editions of the classic, Hopkins-written medical textbook, *The Principles and Practice of Medicine*, whose first edition was by Sir William Osler. He also is a member of the National Academy of Science's Institute of Medicine. His list of accomplishments, clearly, is too long for one journal article.

His most traumatic moment as dean came in 1979 when medical student Alan Trimakis was shot to death, "a victim of random, senseless, neighborhood violence." Among the best moments were watching as Hopkins researchers Hamilton Smith, M.D. and Daniel Nathans, M.D. received the 1978 Nobel prize in medicine for their discovery of how to slice genes, and leading the 1989 celebration of the Centennial of Hopkins Medicine.

On recruiting good faculty and the "triple threat"

In the end, Ross says, "people make the institution. It's not the buildings, not the facilities. And you get good people by being very careful in recruiting." Painstaking recruiting, he notes, is a Hopkins tradition. "Whatever their differences, Welch, Osler, Halsted, Kelly, Billings, and all the members of the first faculty understood what it meant to live and work at Hopkins. When they selected their successors, they chose people who were sympathetic to the spirit of the place and would sustain it." Each generation beget the next. "The genetic analogy is obvious," Ross says. "I believe the quality of excellence that is Hopkins is a sacred responsibility; to ensure that the quality is replicated, you can't break that chain."

It has gotten harder, he acknowledges, in these times of increasing

tions. I liked Baltimore and I liked Hopkins, so becoming dean at Hopkins seemed like a nice opportunity. I could stay in an institution that I knew, move beyond the limited field of cardiology, and get a new start. I think every once in a while people need to do something different to revitalize their lives. You reach into yourself and pull out resources that you didn't know you had. It was a turning point in my career.

Dr. H: When you accepted the position, what did you expect the role of dean to be? Did your expectations remain unaltered and were you surprised by what was actually required?

Dr. R: Since I had been a clinician, I wanted clinical medicine to play a bigger role in medicine. I wanted to have more of an impact on the direction of the clinical departments than I did. It was difficult because Hopkins is a cumbersome organization.

Over one hundred years ago, Mr. Johns Hopkins said, "In my will, I'm going to leave seven million dollars. I want it divided into two pieces. I want a board of trustees to take half of it and build the university, and I want a separate board of trustees to take the other half and build a hospital." Then he said, "I hope that in the fullness of time, the university will have a medical school that will work closely with or use my hospital for its teaching."

That dual relationship causes a great deal of difficulty, and I think it's time for a single leader. It's difficult for the dean and the chairpersons of the clinical departments to have two loyalties—the hospital and the medical school. If there were a single person or organization to which both organizations reported, that would make life a lot easier. I was frustrated by that division.

I did spend a great deal of time with the clinical departments. Getting to know the basic science departments was really a wonderful experience. I made good friends in the basic science departments. I got a feeling for the excitement of research at the cutting edge, and I devoted a tremendous amount of energy and money to building up our basic science departments. I think we have an extremely strong unit now. At the time I left, we were one of the top two institutions in the country in terms of grant

specialization, to recruit "triple-threat" department chairpersons, who are good in teaching, patient care, and research—the synergistic triangle of academic medicine. Is it realistic even to try nowadays? "I'm not sure," Ross says. "We seem to have done pretty well. However, it is a problem. We can't have everybody who is good at everything. Maybe what we have to do is try to maintain balance within the department or unit." Medicine, he adds, has expanded beyond the ability of "even the best" to excel in every area. "Nevertheless, department directors can ensure that all three sides of the triangle are equally strong in the department, if not in each individual."

Has the Hopkins deanship gotten too big? "Sometimes I think it has," Ross says, somewhat wistfully. "Many years ago, the deanship was a part-time job. Somebody told me that when William Henry Welch (the first dean at Hopkins) had the job, he would have office hours—'The dean will be in from 3 to 4 on Tuesday afternoon.' That was all it took. But it's pretty clear now it's not only a full-time job, but in addition to one person's activity, it takes a tremendous staff, and I've gotten a lot of support from a great number of people."

"It's worrisome in a way, because one of the best things about this place in comparison to other, bigger institutions, has always been its small size," Ross says. "I think I can still say—although it's getting more difficult—that the great advantage of Hopkins is that it's small enough that each individual can make a difference to the institution. And yet Hopkins is big enough that it has an impact nationally. Now, if it gets much bigger, it's going to be hard for the first part to be true."

If he had it to do again, would he take the job? "That's the acid test," says Ross, "and the answer is yes." Since his retirement, friends have asked Ross if he enjoyed being dean. "My standard answer has been, 'Yes, 51 percent of the time.'" But, he jokes, "it's really much better than that—possibly 52 percent." Certain aspects of the job he loved—becoming a generalist, for instance. "I started out as a cardiologist. I knew a lot about the heart. Now I've shifted from knowing more and more about less and less to knowing a little bit about a lot of things. I enjoy that very much." Ross often concluded visits from young faculty by asking about their research. "I think the most fun has been in getting to know a lot of bright young people who come through this office and are willing to teach me something."

How would he like people to remember his deanship? "As an exciting, pleasant, stimulating time to be part of the Johns Hopkins Medical Institutions," he answers, "I've tried to make it that way for people, sometimes shielding them from the risks and the unpleasantness that are there. That may not always be good," he adds. "But I think in order to be productive, people have to be able to concentrate, to focus on what they're doing. One of the jobs of the dean is to provide a bit of shelter, a buffer against external forces which, if they were to have full impact on the faculty, would seriously impair their creativity and effectiveness." ■

money from NIH. A lot of that was due to the basic sciences.

The basic science people are out there on the frontier. They've got to be productive and relate to the clinicians in order to see the place move ahead. I think that's one of the great strengths of Hopkins. At other universities, such as Harvard, the basic science chairperson has no contact whatsoever with the clinical chairperson. They don't know each other, and they certainly have no collaborative projects or relationships. At Hopkins, the head of biochemistry sits next to the head of surgery once a month at an advisory board, and they talk to each other. They serve on committees together, and this collaboration fosters cooperative relationships.

We have bridges from this building that connect to the hospital, to the Traylor Research Building, and to the basic science complex. I think those bridges are symbolic of the relationships that we have been able to develop. I think it's better here now than it's ever been.

Dr. H: What other areas would you describe among your achievements?

Dr. R: I've recruited almost all of the current department chairpersons. I think the most important thing any dean does is to put his or her stamp on the institution through the people that are selected. Now there are search committees, and they come up with a panel of people. But, it's the dean who talks to the candidate and decides on the amount of money and space the candidate will receive. Therefore, the final decision with regard to recruiting people is the dean's.

One of the strengths of Hopkins has been its people. I guess it's true of every institution, but Hopkins is different. Drs. Osler, Welch, Halsted, and Kelly picked their successors, and then their successors picked their successors. When I came here, there were older men around who knew Osler and had studied under him—it's not that long ago. That tradition is important in keeping the heritage of excellence that we all talk about. It's almost like Hopkins has excellence in its genes. Its people may live and die, but the genetic material keeps

moving along through generation after generation.

Dr. H: In terms of medical education, do you think the way we have been teaching medical students for the last thirty years is something that needs to be changed?

Dr. R: I certainly do. My successor is working very hard on that. He has it on the top burner. We also need to promote a better distribution of doctors with skills that are more related to what the population needs. We need more people in family practice and general internal medicine.

Partly because of financial incentives and partly because it is so much fun, we've attracted a disproportionate share of students into the high tech specialties like orthopaedics, ophthalmology, and cardiology. We don't have a lot of people who are willing to pursue primary care.

Dr. H: How do you encourage medical students to undertake careers in primary care?

Dr. R: By changing the curriculum. Any time the dean of a medical school decides to change the curriculum, it's almost always good for the students because change gets a new group of people interested in teaching. Change provides a stimulus to rewrite lectures and to examine what is being taught.

I'm not sure that any new curriculum design is as important as the process of change. Unfortunately, medical education is like a stepchild in the medical school. It shouldn't be, but it is. Most institutions are driven by their sources of revenue. In this institution, we are driven by the power of our research enterprise.

During my tenure, I took money from the dean's funds and pumped it into graduate education to train physicians to conduct research and to be clinical teachers. I concentrated on this more than I worked on encouraging medical students to enter primary care.

Dr. H: In terms of research, what would you point to as being the most meaningful achievement?

Dr. R: Number one would be the explosion in genetics. Hopkins is fortunate to have a number of power houses in this area, including Victor McKusick, M.D. on the clinical side and Drs. Nathans and Smith and their colleagues in the laboratory. Bert Goldstein, M.D. in the Oncology Center is applying the new information on genetic diseases to the study of colon cancer. He now knows what makes the tumor become malignant and what the genetic mechanism is.

Dr. H: In terms of the future, what do you see as the main challenges facing this institution?

Dr. R: Money is going to be a real problem. I tried to prepare for that by accumulating about twenty million dollars in reserves for the school of medicine. The money was intended for a variety of things but mostly to act as a cushion against uncertain times. But then in 1989, the university had a financial crisis. The following year, President Mohler took that twenty million dollars from the school of medicine to plug holes in the university's arts and sciences programs. So now we don't have that cushion. I didn't leave the financial legacy for the new dean that I had intended.

Another problem is Hopkin's location in the inner city. We need patients and we need young people in training. If they don't feel secure, they're not going to come here. So, the security has to be improved. Improving security has to involve the surrounding neighborhoods. A lot of that's been done already; we have been a catalyst for the development of better housing.

Dr. H: Being dean for so many years has certainly been a very unique experience for you. How do you plan to make use of that experience after you retire?

Dr. R: I'm not sure. Some of my predecessors have written books, but I don't have a great burning urge to write a book. I am, however, going through file boxes. I have about 180 boxes of papers that were cleared out of the office when I left. I try to spend a couple of hours each day going through a box and writing a little summary of what's in each one.

When I reach 70, I'll fully retire. My wife and I have a place in Florida, and we'll spend some more time down there. I'd like to travel, play some golf—enjoy myself.

One thing I didn't mention—one of the gratifications about being the dean—has been the opportunity to be a generalist. I've said this over and over again. I spent the fifteen years before I became dean as a cardiologist, learning more and more about one little organ. When I became dean, I had to learn what the people in biochemistry were doing, learn what the orthopaedic people were doing, etc.—I became a generalist. It has been wonderful to have a broader view of medicine than a person has if he or she is in just one medical specialty.

All in all, it was a gratifying experience. I love the institution. I think it has great strength and a fine future. As dean, you are, to a certain extent, a salesman who attempts to sell the institution to recruits—for faculty, for physicians, and for medical students. You sell it to people. I would not have thought I could do that, but I found that if you have a good product, the facts are strong, and you're enthusiastic, it's fun. That's what I've enjoyed doing. ■

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Information for AUTHORS

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1. Stevens MB. The clinical spectrum of SLE. *Md Med J* 1991; 10:875-85.

2. Ropes MW. Characteristics, manifestations, and pathologic findings. In: Ropes MD, ed. *Systemic Lupus Erythematosus*. Cambridge, MA: Harvard University Press. 1976; 50-4.

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Papillary muscle rupture: A reversible cause of cardiogenic shock

Eric Chwa, M.D.; Angeles Gonzalez, M.D.; Raymond D. Bahr, M.D.;
Anil Fatterpaker, M.D.; Alfred Cassale, M.D.; and Ronald E. Gillilan, M.D.

Acute papillary muscle rupture after myocardial infarction, with accompanying pulmonary edema and cardiogenic shock, is an emergency condition leading to high mortality without surgical treatment.

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In 1948, Davison reported the first antemortem clinical diagnosis of papillary muscle rupture secondary to acute myocardial infarction.¹ He described the case of a 55-year-old man who after several days of recurrent chest pain presented with congestive heart failure, hypotension, and a loud systolic heart murmur. The patient did not survive with medical management, and the postmortem examination showed rupture of the posterior papillary muscle.

Treatment efforts for postinfarction papillary muscle rupture were seldom successful prior to 1965. With medical management alone, the mortality for this condition was 30 percent immediate, 50 percent in 24 hours, and 96 percent beyond two months.² Prior to 1970, there were sporadic reports of surgical success in the treatment of this condition.³ Surgical correction of the mitral regurgitation was frequently delayed for weeks or months. Thus, the more seriously ill patients often did not survive to have surgery. In some earlier series, the overall operative mortality for this condition was roughly 50 percent.⁴

Better understanding of the pathophysiology of this condition was essential to improved survival. In 1979, Wei et al found thirteen cases (5 percent) of ruptured papillary muscle in an autopsy series of 260 patients who died of acute myocardial infarction over a twenty-one-year period.⁵ Most patients in this series had a small area (mean, 19 percent) of left ventricle infarcted, with sparing of the mitral valve annulus. Since shock from pump failure due to myocardial necrosis generally involves more than 40 percent of left ventricle, Wei et al suggested that early surgery is not only feasible but can reverse cardiogenic shock secondary to papillary muscle rupture. A few case reports in the 1980s showed that early surgical intervention achieved a better outcome. Killen et al reported an actuarial

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five-year survival of 75 percent in nine patients who underwent surgical correction within three days of papillary muscle rupture.⁶ Nishimura et al found 100 percent perioperative survival in seven patients who had prompt (within four days, and within one day in five of seven patients) surgery.⁷ Six of the seven patients in the latter series were alive after 9.7 months.

Technological developments during the past several decades have contributed to the improved outlook for such patients.⁸ Echocardiography and Swan-Ganz catheterization provide a readily available means of early bedside confirmation of the clinical impression. Intraaortic balloon pump counterpulsation during transportation, testing, and preparation of the patient provide more effective circulatory support before surgery.

Since this condition is relatively uncommon and definitive treatment requires cardiovascular surgery, the reports in the medical literature to date reflect the experience of large medical centers. The published experiences often include only a few patients collected over a number of years. For example, Nunley et al, working at the Oregon Health Sciences University and St. Vincent Medical Center, reported the surgical experience, with six patients who had complete papillary muscle rupture, collected over an eleven-year period.⁹ Similarly, Clements et al, at Emory University Hospital, encountered fourteen such patients over an eight-year period.¹⁰

We report five cases of acute complete papillary muscle rupture detected in one year at a community hospital. This community hospital experience with a substantial number of such patients shows that timely diagnosis of the condition can be accomplished with available bedside technique. Collaboration for cardiovascular surgery with a nearby institution achieved an outcome for the patients that is comparable with that reported in the recent medical literature.

Facilities and methods

All patients in this study presented at St. Agnes Hospital—a 430-bed community hospital with a twelve-bed acute coronary care unit in Baltimore, Maryland. The usual intensive care monitoring, Swan-Ganz catheterization, and noninvasive testing with transthoracic echocardiography were carried out at this institution. The intraaortic balloon for counterpulsation was inserted by a cardiology fellow from the receiving institution who accompanied the patient to the Johns Hopkins Medical Institutions. A coronary care nurse was in attendance during transport. Patients were transported by ambulance, with continuous electrocardiographic and hemodynamic monitoring during the roughly six miles to the Johns Hopkins Medical Institutions for definitive therapy. Approximately thirty minutes were required for the trip.

We reviewed the hospital records of all patients who had the discharge diagnosis of acute myocardial infarction during the year 1989 at St. Agnes Hospital. There were 372 cases with established acute myocardial infarction, including eighteen patients who had cardiogenic shock and five patients with acute papillary muscle rupture.

Medical charts from both institutions were reviewed on these five patients. Data reviewed included prior history of coronary disease, time of onset of chest pain, elevation of cardiac enzymes, electrocardiographic features of infarction, development of hypotension, appearance of systolic heart murmur, signs of pulmonary edema, pulmonary congestion on x-ray, and giant V waves on Swan-Ganz pressure readings. The doppler echocardiographic features reviewed included ventricular function, atrial size, and presence of mitral regurgitation with and without visualization of papillary muscle rupture. We also reviewed the use of intraaortic balloon counterpulsation, cardiac catheterization reports, and anatomic findings of surgery and/or autopsy. Follow-up information was obtained from the attending physicians and from a quality-of-life questionnaire administered by telephone.

Clinical features and outcome

The clinical data and results of treatment are shown in the Table. Of the five patients, mean age 65 years (range, 61–76), four were women and one was a man. Clinical, electrocardiographic, and cardiac enzyme criteria for the diagnosis of acute myocardial infarction were present in each of the five patients. This represented the first myocardial infarction for all five patients. After a mean period of 4.2 days (range, 1–10) following the onset of chest pain, all patients suddenly developed acute pulmonary edema and shock. New apical systolic murmurs were heard in four of the five patients. Chest x-rays showed pulmonary edema in all patients. Doppler echocardiogram was performed in four patients and showed mitral regurgitation. All five patients had Swan-Ganz catheterization showing the characteristic giant V waves. Cardiac catheterization, performed as an emergency procedure in four of the five patients, showed significant (greater than 50 percent) obstruction of three coronary arteries (right, left anterior descending, and left circumflex) in three patients and of two coronaries (left anterior descending and left circumflex) in one patient. An autopsy performed on the one patient who refused cardiac catheterization revealed significant obstruction of two coronary arteries (right and left anterior descending). Characteristic features by noninvasive and invasive studies showed fair to good left ventricular function, normal left atrial size, and severe mitral regurgitation in all patients.

Once the diagnosis was confirmed, four of the five patients were transferred to Johns Hopkins Hospital for cardiac surgery. All four patients required intraaortic balloon pump and endotracheal mechanical ventilation prior to surgery. All had mitral valve replacement and coronary bypass surgery within twenty-four hours of the first clinical manifestation of mitral regurgitation. One patient refused surgical treatment, was not transferred for surgery, and expired within twenty-four hours of the appearance of mitral regurgitation. Operative findings on four patients and an autopsy report on one patient revealed that three patients had posterior and two had anterior papillary muscle rupture at the trunk. Postoperative complications included sepsis and transient renal failure in one patient who

Table. Characteristics of five patients with papillary muscle rupture

Patient	EB	CCh	CC	LM	RS
Age	76	66	67	61	67
Sex	F	M	F	F	F
Previous MI ^a	N	N	N	N	N
MI location	Inferior	Inferior	Inferior	Inferior	Posterior
CPK ^b elevated	Yes	Yes	Yes	Yes	Yes
Days after MI	2	4	4	10	1
Acute dyspnea	3+	4+	4+	4+	4+
Shock	Yes	Yes	Yes	Yes	Yes
Systolic murmur	Yes	Yes	Yes	Yes	Yes
Chest x-ray	PE ^c	PE	PE	PE	PE
Swan-Ganz cath ^e	V wave	V wave	V wave	V wave	V wave
Echo: Mitral	Flail	No data	Flail	Flail	Acute MR ^d
Cardiac cath	Yes	Yes	Yes	No	YES
LV ^f function	Fair	Fair	Good	Fair	Good
Atrial size	Normal	Normal	Normal	Normal	Enlarged
Balloon pump	Yes	Yes	Yes	No	Yes
Surgery	CABG ^g	CABG ^g	CABG ^g	None	CABG ^g
# Of vessels	2	2	4	2 ^h	2
Pmr ⁱ location	Posterior	Anterior	Anterior	Posterior	Posterior
Complications	None	Yes ^j	None	Death	Small stroke
Prosthesis	Mitral	Mitral	Mitral		Mitral
Follow-up					
Months	28	17	27		28
Life quality	Good	Poor ^k	Good		Good

- a. Refers to myocardial infarction
- b. CPK creatinine phosphokinase
- c. Pulmonary edema
- d. Mitral regurgitation
- e. Catheterization
- f. Left ventricular function

- g. Coronary artery bypass graft
- h. Postmortem finding
- i. Papillary muscle rupture
- j. Recovered from postoperative sepsis and renal failure
- k. Paralysis from stroke occurring one year after surgery

recovered completely, and a cerebrovascular accident in another who recovered 80–90 percent of function after rehabilitation.

In the mean follow-up period of 23.6 months (range, 17–28), all patients who received surgical treatment are alive, free from chest pain, and without exertional dyspnea. One patient suffered a stroke one year after surgery and is limited physically by hemiparesis. The other three patients report a good quality of life.

Discussion

Acute papillary muscle rupture after myocardial infarction, with accompanying pulmonary edema and cardiogenic shock, is an emergency condition leading to high mortality without surgical treatment.

In 1989, the incidence of papillary muscle rupture was 1.3 percent (5 of 372 patients) in our patients with acute myocardial infarction. This condition is an uncommon complication of infarction and our cluster of cases in one year does not reflect the true incidence of the papillary muscle rupture. Cederquist and Soderstrom reported a slightly lower incidence (0.86 percent) of this complication in their autopsy series of 578 patients with acute myocardial infarction.¹¹ While the condition may be relatively uncommon, it represents a potentially reversible cause of cardiogenic shock.⁵

The anatomy of the heart is the basis for understanding this disease condition, and the pathophysiology explains why prompt surgery is essential. There are two groups of papillary muscles in the left ventricle—the posterior medial and anterior lateral. Chordae tendineae from each papillary muscle head are distributed to both mitral valve leaflets. Therefore, disruption of a single papillary muscle can modify the function of both mitral leaflets and lead to severe mitral regurgitation.

The anterior papillary muscle has a double blood supply from anterior descending and left circumflex coronary arteries, while the posterior papillary muscle is supplied by a single vessel, either the right coronary artery or the left circumflex artery in a left dominant coronary system.¹² Thus, the posterior papillary muscle is more vulnerable to injury than the anterior. Wei et al postulated two factors promoting disruption of papillary muscle during the four to six days after myocardial infarction: (1) prevalence of cell disintegration and reparative response in the involved myocardium at that time, and (2) the hemorrhagic infiltration of interstitium, possibly acting as a dissecting mass of blood.¹³

A high index of suspicion is necessary in patients who suddenly develop pulmonary edema and shock, especially when associated with a new murmur, a few days after acute myocardial infarction. The time between onset of chest pain due to myocardial infarction and the signs of papillary muscle rupture (a mean of 4.2 days in our series of patients) represents that period of time during which the myocardium is most

vulnerable to rupture due to the progressing myocardial necrosis. For this reason, rupture of the free wall of the myocardium or development of ventricular septal defects occurs in the same time frame and must be considered in the differential diagnosis.

While a loud holosystolic heart murmur is a common feature of both ventricular septal defect and papillary muscle rupture, and murmur is usually absent in rupture of ventricular free wall, the presence of a palpable thrill (which none of our patients had) is sometimes helpful in detecting the patient with perforated ventricular septum. The doppler echocardiogram (detecting mitral regurgitation with papillary muscle rupture, intracardiac shunting with ventricular septal defect, and pericardial effusion with ruptured free wall of the ventricle) and Swan-Ganz catheterization (showing giant V waves with papillary muscle rupture and oxygen step-up in right ventricle with ventricular septal defect) are particularly useful techniques in distinguishing among the three entities.

The diagnosis of papillary muscle rupture by conventional transthoracic echocardiography may be difficult with technically suboptimal images being obtained in the intensive care setting. Transesophageal echocardiography is an effective method that can provide clear images of the mitral valve apparatus to assist in the bedside diagnosis of their condition.¹⁴ Cardiac catheterization and coronary angiography done as an emergency procedure confirms the diagnosis of mitral regurgitation, further defines ventricular function, and provides data on the extent of coronary artery disease.

At the time of this study, intraaortic balloon counterpulsation technology was not available at St. Agnes Hospital. The portable nature of that technology and prompt collaboration with another cardiac surgical center enabled the timely transfer of our patients for surgery. Gottlieb and coworkers recently reported their experience with eleven patients who had refractory ischemia or cardiogenic shock who were successfully transported from a community hospital to a tertiary treatment center utilizing portable intraaortic balloon counterpulsations.¹⁵ The surgical approach to this condition has evolved over several decades. In the early days, there was a period of waiting for healing of the infarction and stabilization of the patient before surgery, which unfortunately often resulted in further clinical deterioration and death of the patient. In recent times, the prevailing trend has been prompt surgery.^{3,4} With the addition of coronary bypass surgery to mitral valve replacement, more definitive treatment is available to the patient. All four of our patients who had surgery survived and have good quality of life (although one had a stroke) at a mean of 23.6 months follow-up.

In summary, we report our community hospital experience with five patients having postinfarction papillary muscle rupture. Community hospitals have a major role to play in the early recognition and prompt transfer to a surgical facility.

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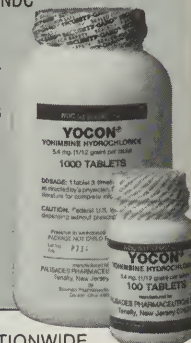
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Instrumental musicians showing technique impairment with painful overuse

Hunter J.H. Fry, M.S., F.R.C.S., F.R.A.C.S. and Glen Rowley, Ph.D.

Among musicians, musculo-ligamentous overuse, or overuse syndrome, is the most common cause of pain in the upper limbs. Impairment of technique can be the result of painful overuse, or it may be the antecedent of it.

Dr. Fry is a plastic surgeon in Australia and a specialist in music medicine. Dr. Rowley is associate professor and associate dean (research), Faculty of Education, Monash University, Melbourne, Australia.

In 1982, Harman reviewed this century's medical literature that dealt in any way with musicians' occupational problems.¹ There were a number of case reports, a little humor, and some exotica. Any well-read doctor reviewing this excellent paper would reasonably come to the conclusion that instrumental musicians had no really serious problems, and that such problems as they had, were somewhat infrequent. One must remember the close connection that has always existed between music and medicine since the time of the Greek god Apollo—who was god of both—up to the modern day situation when whole orchestras may be composed of physicians and where many youth orchestras have a disproportionately large number of medical students among their players. Surely, then, the literature and the conclusions that one could draw from it were completely compatible with physicians' direct experience in real life.

No one, therefore, expected the bombshell of 1983 when Hochberg and his coworkers from Massachusetts General Hospital—reporting from America's first musician clinic—showed that musicians had severe musculo-skeletal problems and described the physical consequences of instrumental playing, which were often severe enough to lead to career loss.² They described a high prevalence of pain in 100 players; about one-third of these players reported loss of control in their hands. When one considers that 600 separate motor actions per second may be required for fingertip positioning in a pianist when twenty notes per second are played,³ the effect on the capacity of the hands to continue as accurately and dexterously as before has to be compromised. While many musicians are able to play with pain, any sort of muscular failure involving their hands is a potential disaster.

It would be fair to say that at the time Hochberg's paper appeared, there would have been few physicians who had any inkling of the seriousness of the problem—the medical author included. At that time, this common use-related pain had been identified in other groups and was generally called tenosynovitis. This was an unfortunate term as it implied a specific

pathology that was never proven, although it was sometimes looked for at operation. It is this same condition, however, that so commonly affects musicians. Musicians may be affected by nerve entrapment, arthritis, cervical radiculopathy, and other causes of pain in the upper limb, but the most common cause of pain is musculo-ligamentous overuse (formerly tenosynovitis), now called overuse syndrome.⁴ This condition is probably at least fifty times more common than all the other disorders put together, as seen in this particular group of people.

Why did we not know about this condition sooner? It is the author's opinion that a number of factors contributed to physicians' lack of awareness. Since physicians were largely unaware of musicians' problems, they were unable to advise musicians effectively and often wondered whether musicians' complaints had an emotional background. Music students were unlikely to complain for fear of being "grounded" or losing their places. Orchestra players dared not complain for fear of losing their jobs for which there were likely to be hundreds of applicants. The great virtuoso players depended on an image of reliability to continue to secure engagements. They, therefore, kept their problems to themselves. When performances or even whole tours had to be canceled due to the pain, substitute reasons were often given for the cancellation.

After the publication of the report by Hochberg et al, many studies followed validating the high prevalence of painful musculo-ligamentous overuse, not only in the upper limbs of instrumental musicians, but also in the facial, palate, throat, and expiratory muscles of wind players.

The present study involves school-age children with painful overuse and impairment of technique. To put this in context, however, one should begin by describing the two types of muscle failure from overuse so that the meaning of the terms will be clear.

Common musculo-ligamentous overuse can be defined as "pain and loss of function in muscle groups and ligaments as a result of excessive or unaccustomed use."⁴ Lederman defines overuse as a result produced when tissues are taken beyond their biologic limits.⁵ These definitions are complementary. Generally speaking, the symptoms date from a period of increased practice, often without adequate breaks between segments of practice prior to a music competition, a recital, or performance examinations. To perfect the most difficult passages, they must be practiced repeatedly; this process is much more physically demanding than the performance itself. Unfortunately, painful overuse mimics a lot of other pain-producing conditions of the upper limb. A mistaken diagnosis may lead to operations, steroid injections, or psychiatric referrals—all of which are inappropriate for overuse. Overuse responds only to rest from the causal and aggravating activities.

The other type of muscle failure from overuse, which is much less common than musculo-ligamentous overuse, is called focal dystonia or cramp.^{6,7} This is a condition of painless loss of coordination that occurs most commonly in musicians' hands. It, too, usually dates from excessive or

unaccustomed practicing. Control is lost, and involuntary movements of the fingers may occur, such as the little and ring fingers flexing down into the palm. Substitute movements may also occur, so that an attempt to carry out one particular movement causes another unintended one to occur. Some particular movements may be impossible to control. Co-contraction of agonists and antagonists has been demonstrated, and the organic, though mysterious, nature of this disorder has received much attention. The types of motor difficulties in any one person are generally quite predictable. It is almost as though the sufferer has a rogue program, akin to a computer virus, that overrides the normal neuromuscular programs. The prognosis for the established disorder is very poor, although in cases in which it is diagnosed early, there may be a response to rest from the causal activities.

In light of the papers by Hochberg et al and Harman, it is ironic that we now realize the nineteenth century literature on musician overuse (both painful and painless) was of a high quality.^{8,9}

Many musicians elect to continue playing despite the presence of pain; pain itself does not hamper the execution of the playing unless it is very severe. However, when technique is impaired in any way, the instrumental musician recognizes it as being a separate element clearly distinguishable from the pain or its effects. Musicians are particularly disturbed by any loss in their technique that is not related to matters they understand, such as lack of practice, ill health, or particular difficulties in a work they are studying. Technique impairment has, therefore, tended to remain a closet symptom to some degree, for it is distressing for the musician to reflect upon present or impending loss of the ability to play music at the previous standard obtained. Thus, it is important to discover any factors linked with impairment of technique in those musicians suffering painful overuse.

An instrumental musician may be aware of more technique "tension"; this may even be externally obvious to the degree that it is noticed by the teacher. Tension is simply another term for co-contraction, where opposing muscle groups inappropriately contract at the same time causing loss of fluency and overstabilization of joints. While there may be many musical causes of technique tension, tension may develop as a direct consequence of overuse and may be mistaken as the cause rather than the effect.¹⁰

Any type of functional muscle loss involving coordination or speed of action will effect technique. Many published studies report such functional loss. Newmark and Hochberg mention co-contraction and its treatment with physical therapy.¹¹ Hochberg et al, writing in 1983, reported that about a third of their patients had some loss of motor control.²

Hiner et al reported multiple problems in technique, apart from pain, in premier violinists occupied in a major competition.¹² Cauldron et al reported six different categories of "loss of facility in playing."¹³ Loss of technique was reported in one series of 485 orchestral players, distinct and separate from their pain and its apparent effects.¹⁴ A larger questionnaire

study by Fishbein et al records that in their sample (inter alia), 23 percent reported decreased motor control and 38 percent recorded weakness in the left hand.¹⁵ Lockwood, in an extensive review, reported his own observations of such patients: "a loss of fine motor control" and "possibly poor motor control which impairs playing."¹⁶ Other studies implied some loss of technique, but the matter was not developed in any detail.^{5,17} In the Melbourne study of use-related pain in secondary school children, nearly a third of the girls and about one-fifth of the boys affected with painful overuse, past or present, reported that their technique was affected.¹⁸ When, however, only current pain sufferers were considered, technique was more often affected in males (five out of seven vs eleven out of twenty-six girls), although it was short of significance. Lockwood noted loss of control or dexterity in school age children in Texas who had painful overuse,¹⁹ although he did not specifically cross tabulate present pain sufferers against technique impairment by gender.

Impairment of technique associated with painful overuse does not respond to disciplined practice and working on the technique alone, as is the case when the primary problem is one of technique itself. In the present study, the painless condition of focal dystonia is excluded, as pain is not a feature of this disorder, and technique is always affected (by definition) and is clearly demonstrable.⁷

Methods

Students ages 7 to 19 who were musically gifted and who attended a specialist music school were studied in relation to impairment of technique associated with music-related upper limb pain. The factors connected with overuse in this sample of 169 child and adolescent musicians have already been reported with respect to pain but not in relation to technique impairment.²⁰ The students enjoyed excellent medical care with the benefit of skilled consultants and a totally sympathetic and caring administration. This student population, however, was not physically examined by the medical author.

Originally, this specialist music school contacted the medical author because of a high level of concern about the students. Because of the wide age spread and because of administrative difficulties, the questionnaire had to be clear and not too long. Questions on pain were restricted to the upper limbs, but a detailed description of sites within the upper limb was not requested. These matters were included in the previous report.²⁰ The questionnaire specifically asked students, "has your technique become impaired," separate from the pain questions. It is the author's perception that the questions were all clearly understood by the students as the school's administrative personnel had all seen the questionnaire and were available to provide explanations on the day the questionnaires were completed. There was a 100 percent response. Twenty-two students were unable to say how long they had experienced pain. Statistical analyses were carried out using chi-square tests.

Impairment of technique was cross tabulated by virtually

every variable that existed within the group, including average and maximum practice hours, age, sex, level of advancement (i.e., grade), primary instrument played and combinations of instruments, and length of symptoms.

Results

The chief interest in this analysis was the discovery of which of the students currently suffering from painful overuse reported loss of technique, and which of the factors were particularly associated with technique impairment.

Apart from a link with gender, age, and length of symptoms, no real links were found on cross tabulation. There were a number of weak trends, for instance with maximum practice hours, but the numbers were too small to assess whether there were any sustained trends between technique impairment and other variables.

Table 1 shows that a significantly higher proportion of male students who had music-related pain also reported technique impairment—about half. By contrast, approximately one-quarter of the female students with music-related pain reported loss of technique. This table also shows that more females had music-related pain in the first place, although a smaller proportion of them reported technique impairment. Although the numbers here are small, the difference in the two groups is so great that there can be no serious statistical argument about the result presented.

Table 2 compares impairment of technique as reported by students 13 years of age or less with those 14 years of age or older. In the younger group, nearly half of those reporting pain also reported loss of technique. In the older students, about one-quarter were so affected. This is on the border of statistical significance and should be accepted as a strong trend.

Table 3 shows the relationship between technique impairment and the length of symptoms. Those musicians having had pain for more than a year reported technique impairment with greater frequency than those who reported having had symptoms for less than a year. The link shown here between length of symptoms and technique impairment can only be classified as a trend since it falls short of statistical significance.

There was no correlation between technique impairment and average or maximum hours of practice. Similarly, there appeared to be no connection between loss of technique and

Table 1
Gender and loss of technique

Gender	Percent who report loss of technique
Male (26)	50.0
Female (57)	26.3

Based on those who reported that they presently experience pain (n=83). $p=.034$

grade level (the standard of difficulty of the work studied) or the instruments played. Even with the cello, where the prevalence of pain was high (seventeen of eighteen players), the proportion of players who also reported loss of technique was no higher than in other groups. No particular instrument or combination of instruments was associated with any trend toward a greater occurrence of technique impairment.

The responses did not suggest a diagnosis of focal dystonia in any of these young students. All students reporting loss of technique in this population did so on a background of music-related pain.

Discussion

While many musicians are prepared to continue to play with music-related pain, the development of technique impairment is a quantum leap in terms of disablement and threatens the future of a performing career, especially in school-age children. These results suggest a greater threat to the technique when music-related pain is present in younger students and in males. In all three studies on school children, females were more vulnerable to music-related pain. However, the present results suggest that once boys develop pain, it is potentially more dangerous. Though the association of technique loss with length of symptoms falls short of statistical significance, the trend is a disturbing one. Genetic differences, of course, exist between individuals, and there may well be many individuals who play with pain for an extended period of time without loss of technique. However, musicians must be aware that continuing to play with pain can ultimately be associated with a continuously increasing risk of technique impairment.

Most studies since 1983 have focused on the occurrence of music-related pain. Pain is a symptom signalling that all is not well. No physician can generally recommend that any patient should continue an activity that causes or aggravates pain. The instrumental musician, therefore, often has to make a personal decision concerning musical activity. It is important that physicians try to discover what factors appear to be associated with more serious threats to the musician's career once music-related pain is present.

One might have expected some correlation between high average practice hours and maximum practice hours with loss of technique. This did not prove to be the case, although a weak trend had previously been noted for pain alone. Since

some students practice for lengthy periods without break, do not space their work out, and do not alternate the type of practice, one would expect them to be more at risk than those who practice longer hours but whose practice is appropriately segmented, who take proper rest breaks, and who plan practice sessions more wisely. The questionnaire did not seek this information.

The only effective treatment for cure of symptoms appears to be rest from the causal and aggravating factors causing the pain.⁴ This usually means some months away from playing and can be a wrenching experience for the instrumental musician. The choice between carrying on music performance in the presence of music-related pain and pain avoidance becomes a choice of the lesser of two evils. It is of great importance to establish whether the loss of technique appears to result from painful overuse or whether it was the antecedent of it.

Conclusions

Further research is needed so that musicians can have early warnings of technique impairment. Most physicians would accept that early diagnosis is preferable and cure more likely. Means must be found to ascertain the early signs of loss of individual digital control before the coordination loss develops to an advanced stage and the performing career is seriously threatened.

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Table 2
Age and loss of technique

Age	Percent who report loss of technique
13 or less (27)	48.1
14 or more (57)	26.8

Data based only on those who reported that they presently experience pain (n=83). p=.054

Table 3
Duration of symptoms and loss of technique

Duration of symptoms	Percent reporting loss of technique
Up to one year (22)	27.3
More than one year (39)	48.7
	(p=.102)

Data based on those who reported that they could specify when it commenced (n=61). p=.102

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Medical peer review, litigation, and the exercise of judgment

Jesse M. Hellman, M.D.

Dr. Hellman is a psychiatrist in Towson, MD and a member of Med Chi's Peer Review Management Committee.

The ambiguity, complexity, and uncertainty that characterize physician discussions of quality care are an inherent and necessary part of the peer review process.

The standard of care that a patient can expect from a physician is a cornerstone concept of both civil litigation and the disciplinary actions of the Maryland Board of Physician Quality Assurance (BPQA). The BPQA relies on peer review committees, formed by the state and county medical societies, as well as specialty societies such as the Maryland Psychiatric Society, to reflect the actual practice standards of competent physicians. This practical framework of physician peer review is invariably affected, in the public's mind, by two emotional and somewhat shadowy factors: our society's increasing mistrust of professional judgment and our increasing trust in specific regulation in place of individual judgment. Both of these factors are themselves affected by our growing reliance on courts and the law.

When a patient complains to the BPQA about treatment received from a physician, and the BPQA finds that the complaint justifies further action, the physician is reviewed by a team that must include physicians from his or her own specialty. In general, the peer reviewers neither directly decide nor suggest specific action—that is in the purview of the BPQA—but rather first determine the standard of care in a particular instance and then determine whether the physician has met that standard. Assistant attorneys general, working with the BPQA, use deviations from the standard of care as the basis for bringing action against a physician's license. While it might appear that a body of codified standards would gradually emerge, this has not been so. In fact, it is unusual to find specific standards that can be readily applied from one case to the next.

To conclude that the members of the BPQA and peer review committees are inherently reluctant to set definite standards would be a serious misjudgment. In order to understand this, consider two very different journeys. On one, a motorist drives from Baltimore to San Diego. In advance, the motorist might be able to plan the route with precision. While there are a number of ways to go, certain turns would definitely be right, others wrong. We could, therefore, see the journey as a linear progression with easily understandable decisions along the way.

The second journey is by sailboat, from Baltimore to Europe. Here, the number of precisely predictable waypoints are few. Two sailors making this journey would never be in the same place, under the same conditions. At any given point, reasonable action would depend on the boat, the sea, the weather, the sailor's experience, and so on in infinite variety. There would be a multitude of decisions, each of which might be workable only if followed by other unforeseen decisions. The sailors would differ in skill and experience; a particular approach, workable to one, could be foolhardy for the other.

This second journey is much closer to the practice of medicine. It is why medicine is an art in addition to a science. On one hand, we might see a patient's treatment as a linear series of decisions that are, or are not, individually correct—a standard of care that was, or was not, met in each instance. While this type of thinking is often useful to help understand a train of events, it often results in an expectation of simplicity. It certainly does not guarantee good care. Often in medicine, one decision depends on another in a complex pattern. Seeing medical practice as similar to the trip to San Diego may be more useful in court than in a medical determination of the quality of care.

Peer review committees may find cases in which a physician met the standard of care in each instance, and yet the care delivered was poor—a musician who has hit all the right notes, yet produced unbearable music. Alternately, excellent care may involve numerous decisions that enter the arena of medical judgment. In court, an attorney may attempt to cast doubt on the wisdom of a series of decisions in order to lead a jury to the impression of below standard medicine.

When attorneys request a review of a medical case, either toward the pursuit or defense of a malpractice action, they are often looking to find that, in a specific instance, a standard of care has or has not been met. If this cannot be demonstrated, the case may be inarguable, either in a malpractice action or in front of the BPQA.

The wish to have specific codified standards quickly comes up against the complexities of medical practice. In no medical specialty is this truer than in psychiatry. Psychiatrists are often called upon to make decisions regarding patients who have had suicidal thoughts. If the patients should subsequently commit suicide, the psychiatrists may be faced with similar questions both from peer review committees and malpractice attorneys:

- Do the standards of care require that the patients should have been hospitalized?
- Or placed on a specific medication?
- Or the families warned to look out for this or that?

It is often in the interest of the plaintiff to establish the presence of turns that should have been made left instead of right, and in the interest of the defendant, to stress the art of medicine and its uncertainty.

Excellent psychiatric care often does not depend on single,

discrete, decisions that can be understood out of context. It is much more useful to recognize excellent care as comprising a pattern of understanding in which responses follow logically in a consistent and reasonable manner. This acknowledges that there may be many appropriate ways of treating patients with suicidal thoughts and of recognizing that an individual decision may not in itself be right or wrong. There are almost always complex decisions that involve an assessment of the patient's flexibility, understanding, ability to work in treatment, and willingness to face the vicissitudes of illness.

An example might be the treatment of a man with severe anxiety, phobias that prevent him from working, a growing sense of isolation and depression, and thoughts that life is becoming unbearable. The situation rapidly deteriorates. The family is both frightened and furious with the patient. They all feel helpless. While treatment may depend on the best possible use of medication, it is also likely that stabilization of the family and the creation of a workable, trusting relationship with the patient will be critical. (Sometimes one hears later that a single remark conveyed to the patient the sense that he or she was at last being heard, thus allowing the patient to return for further treatment. This is as true in general medicine and surgery as in psychiatry. Quite obviously, this essential understanding is unlikely to be conveyed in a progress note, which might be overly influenced by the need to document that the patient is not suicidal at this time: articles on note-writing are most often written from the defensive, forensic, point of view.)

As peer reviewers, we would want to evaluate this psychiatrist's thinking in as broad a context as possible. How did the psychiatrist understand the patient's situation, the family, the relevant psychological forces, the patient's history and personal patterns, and the typical course of others in similar circumstances? Having such an understanding, did the psychiatrist act in a thoughtful and consistent manner?

Two psychiatrists might equally well appreciate a given situation involving a depressed patient and yet arrive at widely differing courses of action. One might, through his or her own experience and personality, be able to work with the family to create a strong support network that could keep the patient out of the hospital, while another equally good psychiatrist might not. It might or might not be in the patient's best interest to be treated as an outpatient, and the decision to attempt outpatient care rests on many factors. What, for instance, does the psychiatrist know about the particular institutions available? What are they likely to do for the patient? What means, and inclination to use them, does the family possess? How is managed care influencing the treatment? What does the psychiatrist know of his or her own abilities and inclinations? While one psychiatrist might do best treating a particular patient in intensive outpatient psychotherapy, another psychiatrist might do best treating that same patient with a hospital stay followed by less frequent visits.

It is often the complexity of these issues and the multiplicity of viable choices that gets lost in court. The litigation

process encourages experts who take polarized positions and who assert them in the face of any explanation, however reasonable and well thought out.

Similarly, while the peer review committees and the BPQA recognize the inherent complexity of the decision-making process, it is only the concrete turning points that are useful for prosecution before the BPQA. Psychiatrists are prosecuted for sexual offenses, Medical Assistance fraud, drug misadventures, and so on; the softer data, however convincing to the committees and the prosecuting attorneys, are of limited value.

The Board of Physician Quality Assurance can act, and appropriately so, only when specific deviations from the standard of care can be proved by the "clear and convincing" standard. Recent efforts to change the burden of proof to the easier-to-establish "preponderance of the evidence" standard used in civil cases will not (if ever successful) improve the practice of medicine. These changes would dampen the art of medicine by putting even greater emphasis in medical practice on provable-in-court decisions. To make the medical review process even more lawyerly is not in the public interest. In other words, a greater number of successful prosecutions in front of the BPQA will not necessarily result in better overall medical care in the community.

While there is a different position encouraged by the medical model as opposed to the legal one, the situation is not simply the intrusion of legal thinking into medicine and psychiatry. Law does, in fact, provide models of clarity and psychological thinking. However, not only do we as a society increasingly make decisions on the basis of what is most supportable in court, we increasingly believe that those decisions are best. Decisions made in that manner are not necessarily best in other contexts. Medicine practiced for the courts—defensive medicine—is not necessarily good medicine.

Many of us are losing our faith in the ability of intelligent

people to make reasonable decisions and exercise good judgment. Regulations, however excruciatingly detailed, cannot create competence. Hospital regulatory agencies, for instance, have required psychiatric hospital records to reflect a symptom and goal-oriented format to the extent that, in spite of having become increasingly voluminous, records frequently lack essential psychological content.

Another example of this in medicine is seen in the Maryland Medical Practice Act itself. Section 14-504 provides the grounds for disciplinary action against a physician. The first six grounds include immoral or unprofessional conduct, professional incompetence, and abandoning a patient. They would cover, one might think, any eventuality. Number 13 is failing to provide details of a patient's medical record. Number 23 (repealed last year) is performing an abortion outside a licensed hospital. Number 27 is failing to educate a patient being treated for breast cancer of alternative methods of treatment.

At one time, it was sufficient to simply state "unprofessional conduct" as a ground for action, presuming that competent boards would understand this and be able to act accordingly.

Today, we increasingly tend to trust that justice is better served if individual judgment is avoided. To what extent has the process of litigation fostered this new American attitude? To what extent does our increasing expectation that medicine or life can be made into a drive to San Diego lead to our ever greater reliance on litigation?

The success of the Board of Physician Quality Assurance rests on physician peer review. The ambiguity, complexity, and uncertainty that characterize physician discussions of quality care are an inherent and necessary part of the process. We, as physicians, need to appreciate the diversity, complexities, and subtleties in our work. This, in the end, is an important element in maintaining the art of medicine. ■

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Primary tumors of the ovary and colon associated with pseudomyxoma peritonei

Ira R. Horowitz, M.D.; Douglas Lakin, M.D.;
Gayatri Ramani, M.B.B.S., M.S.; and John L. Currie, M.D.

The patient presented had primary tumors of the ovary and colon in association with pseudomyxoma peritonei. Since pseudomyxoma peritonei has been associated with mucin-producing tumor of the genital and gastrointestinal tract, a thorough evaluation of the gastrointestinal tract should be performed in patients thought to have pseudomyxoma peritonei secondary to an ovarian neoplasm.

Dr. Horowitz is assistant professor, Gynecology and Obstetrics and Oncology, the Johns Hopkins Medical Institutions, and director, Gynecologic Oncology, Union Memorial Hospital. Dr. Lakin is an internist in Paradise Valley, Arizona. Dr. Ramani is an obstetrician-gynecologist at the Father Muller's Hospital in Karnataka, India. Dr. Currie is director, Gynecologic Oncology, and associate professor, Gynecology and Obstetrics and Oncology, the Johns Hopkins Medical Institutions. Reprints: Ira R. Horowitz, M.D.; Director, Gynecologic Oncology; The Union Memorial Hospital; 201 E. University Pkwy.; Suite 474, Professional Bldg.; Baltimore, MD 21218-2895.

Pseudomyxoma peritonei, frequently referred to as mucinous ascites, is a condition in which all peritoneal surfaces, including bowel, mesentery, and serosa, are covered with either a homogenous gelatinous material or cystic gelatinous masses. The patient's course is usually unpredictable with a high recurrence rate, prolonged survival, and ultimate death from intestinal obstruction.

In 1884, Werth¹ described a gelatinous material in the peritoneal cavity as having its origin from a ruptured pseudomyxoma cyst of the ovary. Fraenkel,² in 1901, was the first to describe the disease in males as a complication of a ruptured mucocele of the appendix. Although primarily associated with mucinous carcinoma of the ovary and ruptured mucocele of the appendix, pseudomyxoma peritonei has been associated with benign teratomas of the ovary, adenocarcinoma of the ovary, uterine carcinoma, and adenocarcinoma of the colon and small intestine.³

We present a case of pseudomyxoma peritonei associated with two primary tumors—a mucinous ovarian cystadenocarcinoma of low malignant potential and an infiltrating mucinous adenocarcinoma of the sigmoid colon.

Case

The patient is a 62-year-old black female (gravida 0, para 0) admitted to the medicine service for increasing abdominal girth of one to two months duration. Upon admission to the medicine service, a paracentesis was performed that yielded 1 cc of mucin material. Abdomino-peritoneal

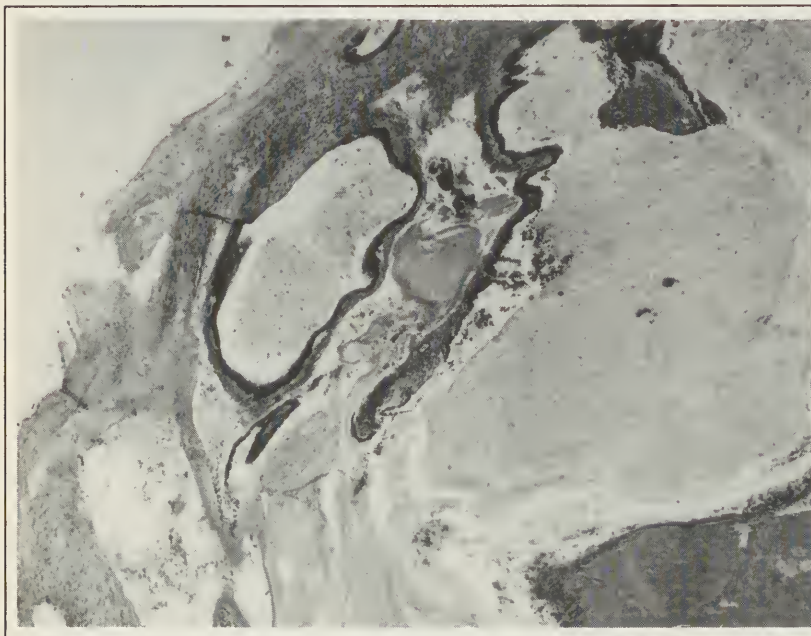


Figure 1. Intraoperative findings were consistent with diffuse intraperitoneal pseudomyxoma peritonei.

computed tomography (CT) revealed a large cystic mass occupying the whole abdomen consistent with an ovarian tumor and a small amount of free peritoneal fluid.

Upon diagnosing the ovarian mass, the patient was transferred to the gynecologic oncology service where she presented with severe hypertension, coronary artery disease, and congestive heart failure. Ninety-six hours after transfer, the patient exhibited signs of a right hemiparesis and hemianesthesia. A thorough evaluation, including CT of the brain, was suggestive of a lower frontal region meningioma. All symp-

toms of hemiparesis and hemianesthesia resolved within five days.

The patient was then taken to the operating room where she underwent an exploratory laparotomy, total abdominal hysterectomy, bilateral salpingo-oophorectomy, omentectomy, and colon resection. Intraoperative findings were consistent with diffuse intraperitoneal pseudomyxoma peritonei (**Figure 1**) and a markedly enlarged right ovary filling most of the abdominal cavity. The tumor had apparently ruptured, and histology revealed a mucinous cystic tumor of low malignant potential (**Figure 2**). Implants on the omentum, mesentery, and serosa of the large intestine were also consistent with a mucinous tumor. A 7 cm mass of the sigmoid colon was identified and excised. Histologic evaluation was diagnostic of an *in situ* and infiltrating mucinous adenocarcinoma of the colon extending into the wall, but not through the serosal surface (**Figure 3**). All four level-two lymph nodes removed were negative for tumor. Histologic evaluation of the appendix revealed a

normal appendix with serosal fibrosis. The patient did well postoperatively and was discharged on her twelfth postoperative day. During the four-year interval since her surgery, the patient has not had a recurrence of her ovarian or bowel tumors.

Discussion

Pseudomyxoma peritonei is a clinical entity consisting of peritoneal mucinous implants and ascites, the origin of which may be malignant or benign. Several theories have been proposed, including metaplasia of peritoneal epithelium⁴ and implantation of mucin-secreting malignant cells.⁵⁻⁷

This case is unique in that two mucin-producing primaries were identified. The colonic lesion was an infiltrating carcinoma that had arisen in a villous adenoma. Although the tumor extended through the muscular wall, it had not penetrated the serosal surface. It is, however, difficult to evaluate a large 7 cm lesion and examine all serosal surfaces for invasion. The presence of long, branching, mucinous glands within the right ovary and lack of a desmoplastic response to the glands strongly supported the presence of an ovarian primary in the right ovary rather than colon metastases.

Although the origin of the tumor within the abdomen cannot be determined with certainty, some features favor an ovarian origin. Most gastrointestinal mucinous tumors that result in pseudomyxoma peritonei are associated with



Figure 2. The tumor had apparently ruptured, and histology revealed a mucinous cystic tumor of low malignant potential.

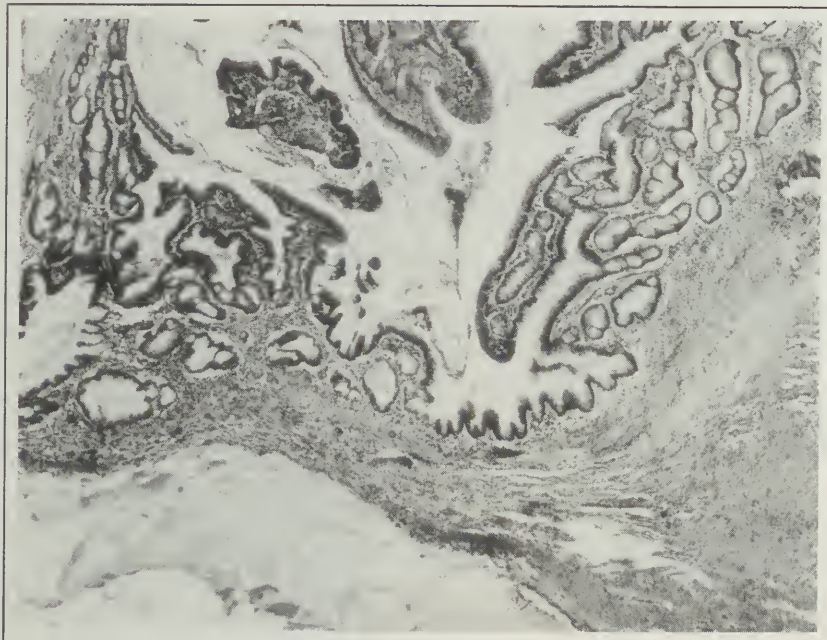


Figure 3. Histologic evaluation was diagnostic of an *in situ* and infiltrating mucinous adenocarcinoma of the colon extending into the wall, but not through the serosal surface.

perforation of the intestinal viscus by tumor; this cannot be shown in this patient.

It is also controversial as to whether there is a direct relationship between these two primary mucinous secreting neoplasms. A previous case report from our institution by Rotmensch et al⁸ described a patient with a multilobular colonic polyp filled with gelatinous material surrounded by tissue without atypical mucosa. Differential stainings with PAS (para-aminosalicylic acid) and Alcian Blue were positive and suggestive of metastasis from the ovarian primary. The concomitant occurrence of an ovarian mucinous cystadenoma of low malignant potential and mucinous adenocarcinoma of the sigmoid colon may be a chance incident. Alternatively, there may be a mucin-secreting stimulant that initiates the formation of mucin-secreting tumors and plays a role in the occurrence of subsequent neoplasms and pseudomyxoma peritonei.⁹ It is imperative that not only the appendix but the small and large intestine be thoroughly evaluated during the patient's work-up to ensure that a second mucin-producing primary or metastatic lesion is not present.

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COMING OUT OF THE DARK

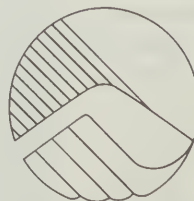
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A Look Back . . .

FOREWORD

George H. Yeager, M.D.
Secretary and Editor

The advent of this publication represents the culmination of the hopes and efforts of the officer body of the Faculty. At the same time, it marks the demise of the *Bulletin* and the incorporation of the *News Letter*.

Scientific articles will be published in as concise a style as possible. Should greater length and detail be desired, access should be made to reprints and the original manuscript.

Circulation figures do not of necessity indicate reader interest. If our state journal is read throughout, a worthwhile service will have been rendered. The argument has been advanced that it will be difficult to obtain articles for a journal of this size. It is our belief that articles published in a journal for state distribution represents more effective reader interest than journals of larger circulation.

We are fully persuaded that the best interests of the Faculty demand some means of binding individual members more closely to the organization. It is imperative that the work of the state society, as well as that of the American Medical Association, be kept before the members.

The facilities of the excellent library of the Faculty, to a very large percentage of our membership, are not available because of geographical factors. Other inducements, as well as some direct means of communication, should be offered. Experience has taught other states that the strongest influence for good in these directions has been a state medical journal, owned and controlled by the state society, managed solely in the interest of its members, and sent

to each of them regularly without cost beyond their annual dues.

Issuance of a journal at this time represents revitalization of an old custom of the Medical and Chirurgical Faculty. The venture

In this edition of the *MMJ*, we begin a new feature—reprinting articles from twenty-five years ago and from forty years ago when the journal was established in its present form.

Reading the articles in "A Look Back" may cause longtime journal readers to reminisce about the "good old days"; new *MMJ* readers may be amazed at the changes in medicine over the years; and both new and long-term Med Chi members may be surprised at how little some things have changed.

As always, the editorial board invites comments about the journal, welcomes input and constructive criticism, and encourages all readers to communicate regularly and often about all facets of the publication and all issues related to the practice of medicine in Maryland.

is neither a "new idea," nor a "new departure."

From October 1839 to June 1843 the Faculty published the *Maryland Medical and Surgical Journal and Official Organ of the Medical Department of the Army and Navy of the United States*. From May 1887 to March 1918 a publication known as the *Maryland Medical Journal* (Vol. 1, 61, #3) carried the notes and communications of the Faculty. For a brief period (1905-1908) this journal became the official publication medium of the Faculty and included the transactions. In 1908 the House of Delegates of the Faculty terminated its contract with the *Maryland Medical Journal* for publication of the transactions and initiated an official monthly *Bulletin*, which was discontinued in 1922. This contained scientific articles, transactions, and local items of interest, and was quite different from the small four to eight page *Bulletin*, which has been published since 1927 to date.

Many objections have been raised to the re-establishment of a journal. Certainly it represents an increased burden for the office staff. If you want a journal, issued by your state society, lend your support. Read it! Criticize it! Help make it worthwhile! If you are willing to include it as essential reading to your professional way of life, then it must succeed.

Add it to your hedonistic as well as your professional pursuits. The probability of the *Maryland State Medical Journal* becoming a fixed asset of the Medical and Chirurgical Faculty of Maryland will thereby be enhanced.

Reprint: *Maryland State Medical Journal*. 1952; 1(1):1-2. ■

American Medical Association

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For Your Benefit

AMA Successfully Obtains 90 Day CLIA Grace Period

The American Medical Association successfully persuaded HCFA to grant a 90-day grace period for the Clinical Laboratory Improvement Act of 1988 during which Medicare claims will NOT be denied if your CLIA registration number is omitted. Health and Human Services Secretary Louis Sullivan, MD,

also upheld the AMA's objections to unannounced surveys of physicians' office labs saying that those investigations will take place only if a problem is suspected or a complaint is filed. Routine surveys during the first 2-year cycle will be educational.

AMA Is Your Advocate in Washington

Physician Advertising. The AMA General Counsel's Office is negotiating with the Federal Trade Commission to develop guidelines for physician advertising. The FTC's Bureau of Competition has approved all the AMA's proposed guidelines and is discussing the last one which deals with claims about the physician's board certification credentials.

Safety Regulations. The AMA urged the Senate Labor Committee to exempt physicians from proposed federal legislation, S. 1622, requiring employers to develop safety and health programs for employees. The AMA pointed out that these regulations duplicate those

existing Occupational Safety and Health Administration requirements that apply to physicians.

HIV Disease. In a letter to the Social Security Subcommittee of the House Ways and Means Committee, the AMA supported legislation that would make it easier for people with HIV disease to receive Social Security disability benefits.

Practice Parameters. The AMA addressed the Agency for Health Care Policy and Research outlining the AMA's views on translating clinical practice guidelines into medical review criteria, standards of quality and performance measures.

Auxiliary

Myrna Goodman: State Auxiliary President

Myrna Goodman is the 1992–1993 president of the Auxiliary to the Medical and Chirurgical Faculty of Maryland. She is the fifth state president from Prince George's County.

Mrs. Goodman was born in the Philippines and is a graduate of the Marian General Hospital School of Nursing in Manila. After passing her nursing boards (R.N.), she worked briefly in a community hospital in Saskatchewan, Canada. She later joined the pediatric nursing staff of the University Hospital in Saskatoon City. She also worked part-time as a petite runway model after the fashion show coordinator for Eaton's of Canada, a popular department store, spotted her while she was shopping. Mrs. Goodman subsequently moved to Toronto and temporarily worked at the post-coronary care unit of Sunnybrook Hospital while waiting for her American immigration papers. She then moved to New York where she joined the Brooklyn Hospital Nursing staff in late 1970, working in the coronary care unit for a number of years. She also took charm classes, graduated from the Barbizon School of Modeling in New York City, and worked part-time as a runway model. She eventually enrolled at St. Francis College as a part-time evening student; she made the dean's list and finished her bachelor of science degree in 1977. Since then, Mrs. Goodman has worked off and on as a nurse part-time.

She worked with her husband in his office full-time from 1983 to early 1986. She did not return to work until 1991, as she was taking care of her son, Jacob, who is currently attending the Jewish Day School.

She and her husband, Stuart J. Goodman, a neurologist, live in Potomac, Maryland. Dr. Goodman, who was born in New Jersey, received his B.S. degree in biology from Oklahoma University. He then went to Tel Aviv University for one year. He received his medical degree from the University of the East, Quezon City, Philippines, in 1977. He did his medical internship at the Brooklyn Cumberland Medical Center in Brooklyn, New York. It was there that he met Myrna, and they married in 1978. Dr. Goodman completed a three-year residency in neurology at Georgetown University Hospital and then undertook a fellowship in electroencephalogram (EEG) and epilepsy at Boston University Hospital. He has been in private practice



in southern Maryland since July of 1982. Dr. Goodman is active with the Prince George's County Medical Society, currently serving as a member of the executive board and other committees. He has worked with various lawyers in educating middle school students about remaining drug free. He has always supported Myrna in her auxiliary activities, adjusting his schedule to fit hers and assisting her when his presence is needed.

Mrs. Goodman has been active with the Prince George's County Auxiliary since 1983. She was the county auxiliary president in 1986–1987. She was the Health Career State Chairperson from 1987 to 1989 and was elected by the state auxiliary as recording secretary for the 1989–1990 year. She was first vice-president in

1990–1991 and president-elect in 1991–1992.

To borrow a popular line, "Reach out and touch someone" is the auxiliary president's message. She hopes to achieve this by encouraging the auxiliary

- to continue its efforts to retain and recruit members,
- to serve and aid the elderly and needy in our communities in order to improve organized medicine's image in the eyes of the public, and
- to work with the medical societies and to convey to legislators and politicians the auxiliary's views and concerns about issues affecting the health of consumers and the future of medicine.

"Awareness is Prevention" is the president's health motto. Under Mrs. Goodman's leadership, the auxiliary will continue to take on breast cancer awareness and the campaign against violence as state projects. All county auxiliaries will be encouraged to do the same.

The auxiliary will also continue to work hand-in-hand with the Medical and Chirurgical Faculty of Maryland in legislative activities, such as the medical rally and the legislative/auxiliary day in Annapolis, in order to strengthen the medical community's relationship with the legislature. At the semiannual meeting in Ocean City, the auxiliary will have speakers on AMPAC (American Medical Political Action Committee) and on legislation to stress the importance and the benefits of involvement.

Mrs. Goodman volunteers for her son's school as needed. She is "a buddy" to the elderly and needy. She volunteers for a nursing home and for a shelter for the homeless in

Montgomery County. She also works part-time in a nursing home and derives satisfaction and humility from working with the elderly and needy.

Mrs. Goodman believes that by continuing the auxiliary's commitment to shared leadership and shared concerns, we can emphasize to perspective members the benefits of legislative and political involvement for the betterment of the health of consumers and the good of the medical profession, thereby making a difference in our communities. ■



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MALARIA (62)

1.3/100,000 (U.S. 0.5/100,000)

Most of the malaria cases (69.4%) were reported from Montgomery and Prince George's counties which have a higher number of refugees and immigrants than the rest of the State. Of the cases with known status (48), 39 (81.3%) were refugees or recent immigrants. The number of cases by jurisdiction is shown in Table 2 (see July, 1992 issue). The male to female ratio was 2.0:1.0. Forty-four cases were black, 5 white, 4 Asian, 3 Hispanic, 2 other race, and the race of 6 was unknown. Ages ranged from 10 months to 71 years (median 33 years). The type of malaria was: *Plasmodium falciparum* (31), *P. vivax* (13), *P. malariae* (4), *P. ovale* (3) and unspecified (11).

P. falciparum and *P. ovale* were acquired in Africa, *P. vivax* in India, Latin America, and Africa, and *P. malariae* in Africa and India.

MEASLES (178)

3.7/100,000 (U.S. 3.8/100,000)

In 1991 measles decreased by 13 percent from 1990 (Figure 10). Most of the cases (87.1%) occurred in March (98) and April (57). Cecil County (68 cases) had the highest rate per 100,000 population (85.2), followed by Howard (21 cases, 11.2) and Calvert (5 cases, 9.4) counties. The number of cases by jurisdiction is shown in Table 1 (see July, 1992 issue). Four cases (2.2%) were imported from abroad or other states. Approximately 120 cases (67.4%), during February, March, and April, from 10 counties, were linked to a wrestler with measles at a high school wrestling tournament. The male to female ratio was 1.3:1.0; the ratio of whites to non-whites was 8.4:1.0. Eighteen (10.1%) were children 0 to 15 months of age, 16 (9.0%) were 16 months to 4 years old, 94 (52.8%) were 5 to 19 years old, and 50 (28.1%) were adults, 20 to 55 years of age. There were

no cases over 55 years of age. The highest age-specific incidence rate (24.1/100,000) was observed among 15 to 19 years olds, followed by the rate among less than 1 year olds (18.3). Only 3 (18.8%) of the 16, 16 months to 4 years of age, had been previously vaccinated. The school age children predominantly had one dose of measles vaccine.

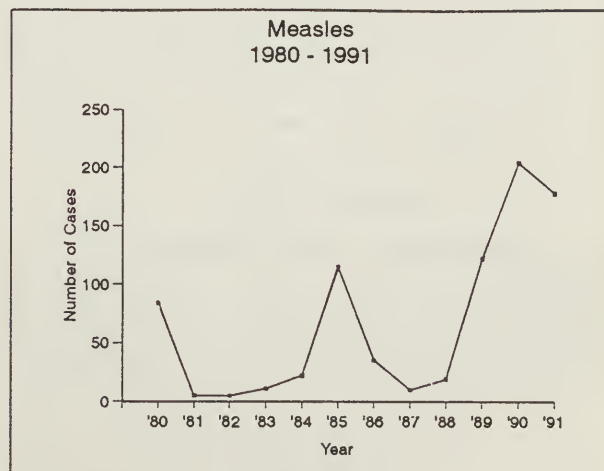


Figure 10

Among those for whom information was available (164), 52 (31.7%) required hospitalization: 70.1% of the preschool age cases, 15.2% of the school aged cases, and 33.3% of the adult cases. Ten of the 48 (20.9%) adults with measles were health care workers.

MENINGITIS, VIRAL (ASEPTIC) (333)

6.9/100,000 (U.S. 5.6/100,000)

Almost two thirds (64.3%) of all cases were reported from the Baltimore metropolitan area and Prince George's and Montgomery counties. The number of cases by county is shown in Table 1 (see July, 1992 issue). The highest rates per 100,000 population were observed in Kent (7 cases, 40.8) and St. Mary's (15 cases,

20.1) counties. Two hundred (60.1%) patients had onset of illness in July, August, and September.

The male to female ratio was 1.0:1.0. The ratio of whites to non-whites was 2.5:1.0. Infants less than 1 year of age (including 5 newborns) had the highest rate per 100,000 population (118.9), followed by the rate among 5 to 9 years of age (11.0). The etiology was reported for only 14 cases: 6 echovirus, 5 coxsackie, 2 unspecified enterovirus, and 1 herpes simplex.

MENINGOCOCCAL DISEASE (35)

0.7/100,000 (U.S. 0.8/100,000)

Eleven counties reported meningococcal disease in 1991. Table 1 (see July, 1992 issue) shows the number of cases by jurisdiction. The incidence declined 22.2 percent from 1990 to 1991 (45 and 35 cases, respectively). Forty percent (14 cases) occurred in January, February, and December.

The male to female ratio was 1.1:1.0. The ratio of whites to blacks was 2.6:1.0; 2 cases were Hispanic. The age ranged between 2 months and 84 years (median 17 years). The highest rate per 100,000 population (9.2) was observed among infants, less than 1 year of age.

Twenty-four (68.6%) patients presented with meningitis, 7 (20.0%) with meningococcemia, 2 (5.7%) with pneumonia, and 1 (2.9%) with pharyngitis; one infection was not specified. The serogroup of the *N. meningitidis* was reported for 7 cases as follows: 1 B, 5 C and 1 W135. The outcome was known for 31 cases (71.4%): 3 died, for a case fatality of 9.7 percent.

MUMPS (236)

4.9/100,000 (U.S. 1.6/100,000)

Mumps declined 79.2 percent from 1990 to 1991 (1136 to 236 cases, respectively). The trend in the past 12 years is presented in Figure 11. Table 1 (see July, 1992

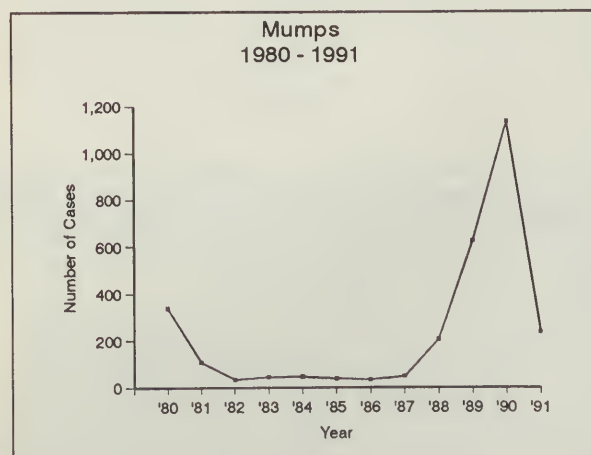


Figure 11

issue) shows the number of cases in 1991 by jurisdiction. Prince George's County (67 cases, 9.3/100,000) and Bal-

timore County (58 cases, 9.4/100,000) reported more than half (53.0%) of the cases. Forty-five percent of all cases occurred in March, April, and May.

The male to female ratio was 1.5:1.0. There were 100 white cases, 100 black, 4 Asian, 2 Hispanic, and 3 other race. For 11.4 percent, the race was unknown. The highest incidence rate per 100,000 population was noted among children, 5 to 14 years of age. Mumps vaccine will be required for kindergarten and 6th grade entry for the first time in September 1992.

PERTUSSIS (61)

1.3/100,000 (U.S. 1.0/100,000)

Cases declined 32 percent from 1990 to 1991 (90 to 61 cases, respectively). The number of cases by county is shown in Table 1 (see July, 1992 issue). Garrett County (15 cases, 52.9/100,000) had the highest incidence rate, followed by Caroline County (3 cases, 10.9/100,000). The cases in Garrett County were part of an outbreak among Amish who were un- or under-immunized. Another outbreak in Cecil County involved 4 local residents and 1 out-of-state case; one infant case transmitted pertussis to a hospital worker who cared for the infant. More than half (54.1%) of all patients had onsets of cough in May, June, and July.

The male to female ratio was 1.2:1.0. The ratio of whites to blacks was 13.0:1.0; the race of 19 cases was unknown. Ages ranged from 1 month to 63 years (median 18 months). Almost a third (18 cases, 29.5%) were less than 6 months old. The highest incidence rate per 100,000 population (38.1) occurred in infants, less than 1 year of age, 53.7 in males and 21.8 in females.

The following symptoms were reported: paroxysmal cough in 54 (88.5%), post-tussive vomiting in 35 (57.4%), whoop in 31 (50.8%), cyanosis in 22 (36.1%), and apnea in 16 (26.2%). Twenty-five patients (41.0%) required hospitalization. Forty-six (42.6%) were laboratory confirmed: 17 (27.9%) by DFA, 2 (3.3%) by culture, and 7 (11.5%) by both DFA and culture. No deaths were reported.

ANIMAL RABIES (579)

In 1991, 11.2 percent (579/5189) of laboratory examined animals were found to have rabies. The trend of animal rabies in the past 12 years is shown in Figure 12. Cases increased 23.7 percent from 1990 to 1991 (468 to 579 cases, respectively). Table 1 (see July, 1992 issue) shows the number of cases by jurisdiction. The rabies epizootic in Maryland started in 1981 in Allegany County and, by 1991, had spread to all counties except Dorchester, Wicomico, Somerset, and Worcester on the lower Eastern Shore. The following counties, all west of the Chesapeake Bay, reported significant percent increases from 1990: Allegany (36%), Anne Arundel (111%), Carroll (50%), Frederick (143%), Montgomery (35%), St. Mary's (25%), and Washington (88%). Because these counties had been originally involved in the

epizootic 6 to 11 years ago, these increases represent an apparent cyclic recovery of the raccoon population and an increase in susceptibles that are now getting rabies. Raccoon rabies accounted for 467 (80.7%) of all cases.

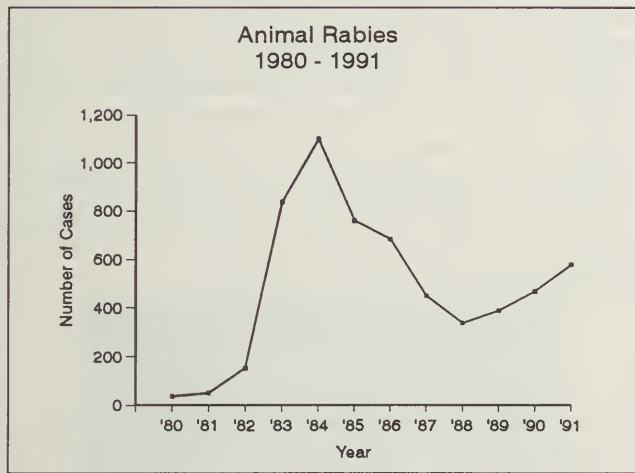


Figure 12

In addition, 51 skunks, 18 foxes, 15 cats, 12 bats, 10 groundhogs, 2 dogs, 1 horse, 1 cow, and 1 beaver were confirmed rabid. There has been no human rabies in Maryland since the epizootic began in 1981.

ROCKY MOUNTAIN SPOTTED FEVER (22)

0.5/100,000 (U.S. 0.3/100,000)

The incidence of Rocky Mountain spotted fever in the past 4 years has remained steady (median 21 cases). The number of cases by jurisdiction in 1991 is shown in Table 1 (see July, 1992 issue). Only 1 case was reported from the Eastern Shore (Caroline County) and none from the counties west of Baltimore County. The highest incidence occurred in St. Mary's County (4 cases, 5.4/100,000). Onsets of illness were in April through September (peak month May with 10 cases).

The male to female ratio was 1.0:1.0. All cases were white. Ages ranged from 2 to 87 years; 50.0 percent were less than 13 years of age, and 50.0 percent were 35 and over. The highest incidence rate (1.7/100,000) was observed among the age group 1 to 4 years. Eighteen (81.8%) patients had rash, including 8 (36.4%) with rash on the palms and/or the soles, and 11 (50.5%) had fever 100.5°F or greater. Eleven (50.0%) patients required hospitalization. Sixteen (72.7%) had tick bite(s), 3 (13.6%) had visited tick infested areas, 1 (4.5%) had no history of exposure, and 2 had no exposure information available. No deaths were reported.

SALMONELLOSIS (1262)

26.3/100,000 (U.S. 19.1/100,000)

The trend of salmonellosis in the past 12 years is presented in Figure 13. The number of cases by jurisdiction in 1991 is shown in Table 1 (see July, 1992 issue). Fifteen outbreaks involving 226 cases (139 of whom were laboratory confirmed and therefore included in the 1991 State total) were reported by 8 counties; one outbreak was state-wide. The Baltimore metropolitan area (Baltimore City, Baltimore County, and Anne Arundel County) reported 41.0 percent (518) of all cases. Half of the cases (50.0%) occurred June through September.

The male to female ratio was 1.1:1.0. Of the 938 (74.3%) persons with known race, 63.6 percent were white, 32.1 percent black, 1.7 percent Hispanic, 1.3 percent Asian, and 1.3 percent other race. The highest incidence rates were observed among infants less than 1 year old (269.8/100,000) and 1 to 4 years old (83.5/100,000). Among adults the highest rate (24.9/100,000) was in age group 20 to 29 years. Twenty-six (2.9%) of the 883 cases with known occupation were foodhandlers.

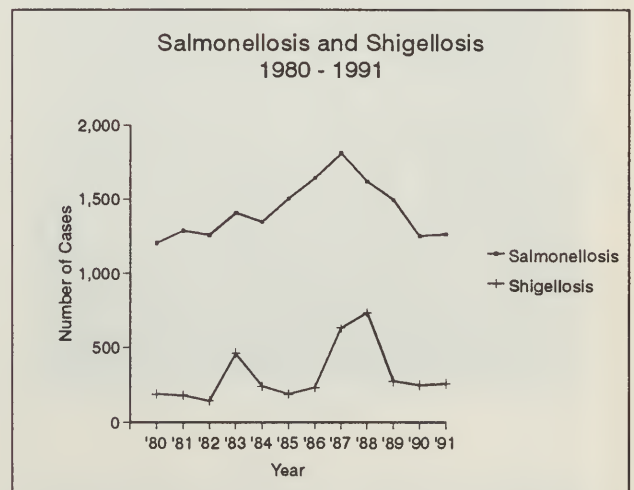


Figure 13

Of the 813 (64.4%) isolates for which serotypes were available, 251 (30.9%) were *S. enteritidis* (vs. 37.1% in 1990), 195 (24.0%) *S. typhimurium*, 71 (8.7%) *S. poona*, 53 (6.5%) *S. heidelberg*, 45 (5.5%) *S. hadar*, 39 (4.8%) *S. newport*, 18 (2.2%) *S. braenderup*, and 141 (17.3%) other serotypes. Five of the 15 outbreaks were caused by *S. enteritidis*, 3 of which were associated with consumption of shell egg-containing food products. Between June 1 and July 15, 64 laboratory confirmed cases of *S. poona* occurred in Maryland. These were part of an outbreak in the U.S. and Canada that was linked to cantaloupe consumption.

SHIGELLOSIS (258)

5.4/100,000 (U.S. 9.3/100,000)

The incidence of shigellosis remained unchanged from 1990. The trend in the past 11 years is presented in Figure 13. The number of cases by jurisdiction in 1991 is shown in Table 1 (see July, 1992 issue). Baltimore City (112 cases) had the highest incidence rate per 100,000 population (15.1), followed by the rate in Queen Anne's County (14.7). Two of the 3 reported shigellosis outbreaks were reported in August.

The male to female ratio was 0.9:1.0. The ratio of whites to non-whites was 0.6:1.0; the race of 74 persons was unknown. The highest incidence rates per 100,000 population were noted in age group 1 to 4 years (20.8) and 5 to 9 (11.3). The most prevalent serogroup was *S. sonnei* (75.7%), followed by *S. flexneri* (21.2%), *S. boydii* (1.8%), and *S. dysenteriae* (1.4%). All 3 reported outbreaks were caused by *S. sonnei*.

SYPHILIS, PRIMARY AND SECONDARY (1016)

20.8/100,000 (U.S. 17.7/100,000)

Primary and secondary (P & S) syphilis decreased 10.6 percent from 1990 to 1991 (1136 to 1016, respectively), the first decrease since 1986. Figure 14 shows the trend of P & S syphilis in the past 12 years. The number of cases by jurisdiction in 1991 is presented in Table 1 (see July, 1992 issue). Prince George's County (453 cases, 61.0/100,000) (Figure 14) accounted for 44.6 percent of all cases. The highest incidence rate per 100,000 population occurred in Wicomico County (131

The male to female ratio was 1.1:1.0. Eighty-six percent of the cases were black. The most affected age group (20 to 24 years) contributed 24 percent of all cases. In 1990 the most affected age group was 25 to 29 years.

Since 1988, all P & S syphilis and early latent syphilis cases seen in local health department STD clinics have been offered testing for HIV. The percent of coinfection in those tested was 17.7 (66/372) in 1988, 16.0 (96/601) in 1989, 7.1 (69/974) in 1990, and 10.8 (94/871) in 1991. Congenital syphilis decreased 33.3 percent from 1990 to 1991 (81 to 54 cases, respectively). In 1991, 37 (68.5%) cases were reported from Prince George's County, 9 (16.7%) from Baltimore City, 2 each from Charles and Wicomico counties, and 1 each from Anne Arundel, Baltimore and St. Mary's counties. Two were stillbirths and 3 died shortly after birth.

TUBERCULOSIS (451)

9.4/100,000 (U.S. 10.4/100,000)

The incidence of tuberculosis increased 17.4 percent from 1990 to 1991 (384 to 451 cases, respectively). The number of cases by jurisdiction is shown in Table 1 (see July, 1992 issue). One third (147 cases, 32.6%) were reported from Baltimore City; 39.5 percent occurred in Montgomery and Prince George's counties (178 cases), 48.9% of whom were foreign-born. The incidence rate per 100,000 population almost doubled in Wicomico (33.6) and Somerset (25.5) counties in 1991, from 17.6 and 15.2, respectively, in 1990.

The male to female ratio was 1.6:1.0. The ratio of whites to non-whites was 0.4:1.0. Thirty-four patients (7.5%) were less than 19 years of age, including 15 who were less than 5 years old; 25.3 percent were 65 years of age and over. A match of tuberculosis and AIDS registries for 1991 identified 36 (8.0%) persons with both diseases, a decrease from the 41 (10.7%) in 1990. Between 1978 and 1991, 119 such cases have been identified. Strains of drug resistant *M. tuberculosis* were noted in 15 patients of which 4 were resistant to at least INH and rifampin.

TYPHOID FEVER (7)

0.1/100,000 (U.S. 0.2/100,000)

No outbreaks occurred in 1991. There was no association among the 4 cases reported from Prince George's County. Table 1 (see July, 1992 issue) shows the number of cases by jurisdiction. Ages ranged from 3 to 44 years (median 29 years). All patients recovered. The cases were imported from the Philippines (2), India (1), Pakistan (1), Nigeria (1), El Salvador (1), and Peru (1). One case was a foodhandler by occupation.

Corrections: In Table 1. Reported Cases of Notifiable Diseases in Maryland by County, 1991 in the July, 1991 issue, the cases of typhoid fever in 1991 should read 7.

The typhoid fever case in Frederick County should be deleted.

Primary and Secondary Syphilis
Maryland and Prince's Georges County
1980 - 1991

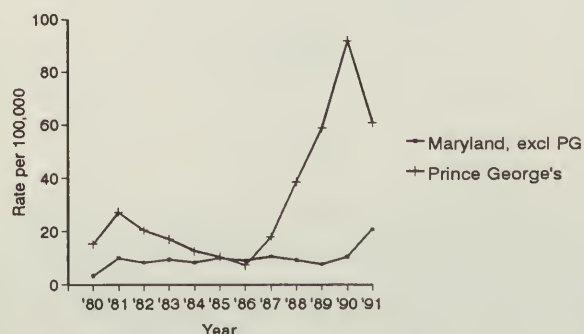


Figure 14

cases, 172.1), an increase from the rate in 1990 (60 cases, 80.7). The rate in Dorchester County, which had the highest rate in the State in the 1989 (117.1) and 1990 (109.1) dropped dramatically to 26.2 in 1991.

Imaging Case of the Month

The patient is a 37-year-old woman with a greater than ten-year history of biopsy-proven multisystem disorder. Clinical neurologic features include intermittent confusion, gait instability, hypothalamic hypothyroidism, hyperprolactinemia, and bilateral intermittent sixth cranial nerve palsies. Pre- and post-enhancement magnetic resonance (MR) images of brain are shown.

*Figures reprinted with permission of Sherman JL, Stern BJ. Sarcoidosis of the CNS: Comparison of Unenhanced and Enhanced MR images. *AJNR* 1990; 11:915-23.

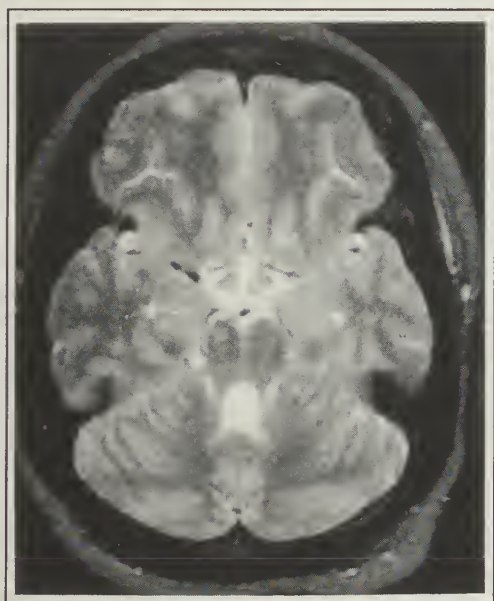


Figure 1A.



Figure 1B.

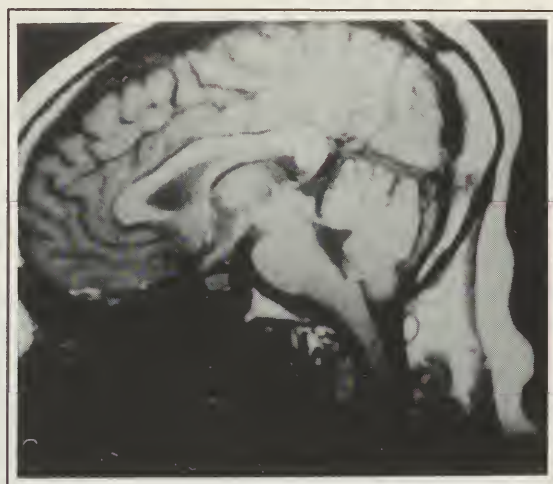


Figure 2A.

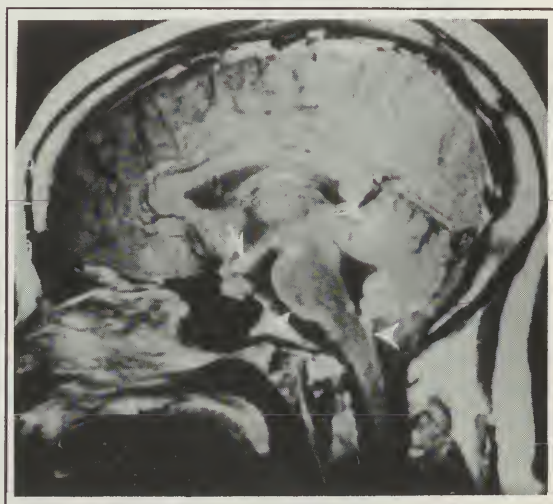


Figure 2B.

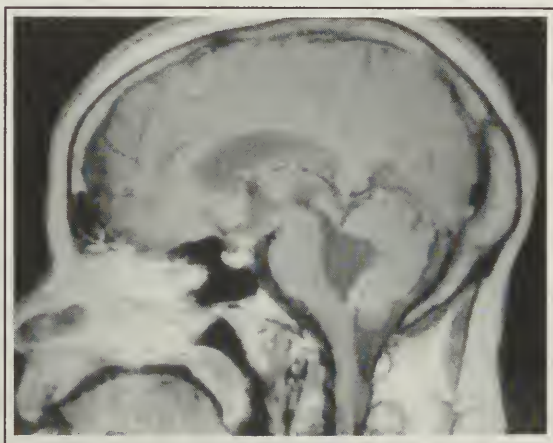


Figure 3.

Imaging Case of the Month

Neurosarcoidosis

Figure 1A. Pre-contrast T2-weighted axial image is unremarkable.

Figure 1B. This is a post-contrast T1-weighted axial image at the same level. Meningeal enhancement is noted around midbrain (short arrow), cerebellum, uncus, horizontal segment of sylvian fissures, interhemispheric fissure, hypothalamus, and optic chiasm (long arrow).

Figure 2A. Pre-contrast T1-weighted midline sagittal image is unremarkable.

Figure 2B. Post-contrast T1-weighted midline sagittal image shows diffuse meningeal enhancement (arrow heads). Note enhancement of chiasm, infundibulum, and hypothalamic region (arrow).

Figure 3. Post-contrast T1-weighted midline sagittal image at eight months follow-up. Meningeal enhancement has been diminished. Note dilated ventricles from communicating hydrocephalus.

Symptomatic central nervous system (CNS) involvement has been reported in 5 percent of patients with sarcoidosis.^{1,2} CNS involvement includes cranial neuropathy, meningeal disease, hypothalamic and pituitary dysfunction, and intra- and extra-axial masses. The most common sites of disease activity in neurosarcoidosis are the basal meninges, especially hypothalamus, infundibulum, pituitary gland, and floor of the third ventricle.

Enhanced MR is far superior to enhanced computed tomography (CT) or unenhanced MR in detecting meningeal involvement.^{3,4} Meningeal enhancement is not specific for neurosarcoidosis and may be seen in cases with bacterial, viral, lymphomatous, or carcinomatous meningitis, many of which may be diagnosed by cerebral spinal fluid (CSF) examination.

Other MR findings of neurosarcoidosis are abnormal areas of high-signal intensities on T2-weighted images at

the gray-white matter junction and periventricular white matter, and intra- and extra-axial mass lesions. Enhancement of intra-axial lesions is uncommon.⁴ Involvement of the hypothalamus and the pituitary stalk is characteristic of CNS sarcoidosis. The combination of high-signal intensities at the gray-white junction on T2-weighted images with meningeal enhancement or with lesions in the hypothalamus should suggest the diagnosis of neurosarcoidosis.⁴

Intravenous contrast (gadopentotate dimeglumine) greatly enhances the sensitivity of MR in detecting neurosarcoidosis and aids in monitoring response to therapy. It is recommended that a contrast agent for MR be used routinely in patients with clinically suspected neurosarcoidosis, especially if the unenhanced images are normal or nonspecific.

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3. Sherman JL, Stern BJ. Sarcoidosis of the CNS: Comparison of unenhanced and enhanced MR images. *AJNR* 1990; 11:915-23.
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Department Editor

PHYSICIAN AUTHORS WANTED

"Imaging Case of the Month" is a regular feature of the *Maryland Medical Journal*. Coordinated by the Maryland Radiological Society, the cases presented provide a review of a broad range of diseases and pathological processes of interest to a wide range of specialists.

Physicians interested in submitting cases for publication consideration should contact the department editor:

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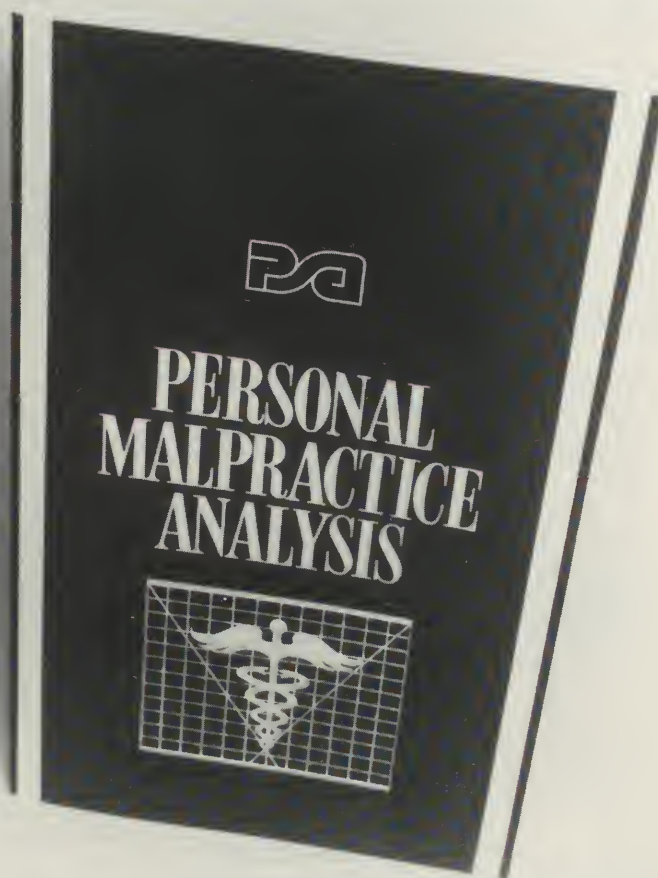
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Third Annual Conference on Addiction: Physician Health & Education

Saturday, November 21, 1992 ■ 1211 Cathedral Street, Baltimore

Sponsored by the Medical and Chirurgical Faculty of Maryland Committee on Scientific Activity in Cooperation with the Physician Rehabilitation Committee

■ 7:30 am – 8:15 am Registration/Continental Breakfast

■ 8:15 am – 8:30 am Welcome
Jose M. Yosunico, M.D., President, Med Chi

■ 8:30 am – 10:00 am What is an Addiction?
This presentation will focus on various behaviors and patterns of substance use with the goal of identifying those disorders that respond to addictive disease treatment and are thus immediately labeled as addictions.

Speaker/Panel Moderator: John R. Steinberg, M.D., Clinical Assistant Professor, University of Maryland School of Medicine; President, Maryland Society of Addiction Medicine.

Panel: Stanley R. Platman, M.D., Professor, Department of Psychiatry, University of Maryland; Medical Director, Psychiatry, Union Memorial Hospital; Chairperson, Med Chi Physician Rehabilitation Committee

Maxwell N. Weisman, M.D., Director, Alcoholism Control Administration (ret.); Past President, American Society of Addiction Medicine (ASAM)

Objectives: Participants will be able to
a. describe the addiction process, and
b. compare and contrast chemical dependence (i.e. alcohol and drug abuse) and compulsive behaviors (e.g. gambling, over-eating) that have recently been referred to as addictions.

CME Credit: 1.5

■ 10:15 am – 11:15 am Patient Placement Criteria Manual (PPCM)
Developed over the past several years, the American Society of Addiction Medicine PPCM is designed to aid physicians in the diagnosis and facilitation of treatment planning for their addicted patients.

Selection of patients for level of care attending to severity of addiction as measured by bio-psycho-social criteria.

Speaker: Barton A. Harris, M.D., Chief, Addiction Medicine, Fort Howard and VAMC-MD

Objectives: Participants will be able to
a. explain the purpose of the manual, and
b. use the manual in the diagnosis and treatment planning of addicted patients.

CME Credit: 1

■ 11:30 pm – 12:30 pm Concurrent Sessions

Session A: Narcotics and Tranquilizers: When is Use Abuse?

This presentation will highlight the differences between medically appropriate and addictive use of narcotics and tranquilizers.

Speaker: Rodney Burbach, M.D., Medical Director, Addiction Treatment Center, Suburban Hospital

Objectives: Participants will be able to
a. identify commonly abused drugs, and
b. identify drug-seeking behavior.

CME Credit: 1

Session B: Effects of Tobacco on Psychotropic Medications

Speaker: Donald Jasinski, M.D., Chief, Center for Chemical Dependence, Francis Scott Key Medical Center

Objectives: Participants will be able to
a. identify psychotropic medications with which tobacco interacts, and
b. counsel patients who use such psychotropic medications in addition to tobacco.

CME Credit: 1

Session C: Litigation Stress

Speaker: Louise B. Andrew, M.D., J.D., FACEP, Assistant Professor, Emergency Medicine, Johns Hopkins University School of Medicine

Objectives: Participants will be able to
a. predict and recognize symptoms of stress imposed by malpractice litigation,
b. learn to respond to them constructively, and
c. use the learned responses to help themselves and others when faced with the threat of malpractice litigation.

CME Credit: 1

■ 12:30 pm – 1:30 pm Lunch (Buffet lunch provided for all registrants)

■ 1:45 pm – 2:45 pm Sexual Misconduct in the Practice of Medicine

Speaker: Charles H. Epps, Jr., M.D., Dean, College of Medicine, Howard University; Member, AMA Council on Ethical and Judicial Affairs

Objectives: Participants will be able to

- define the AMA's policy on sexual activity between physician and patient, and
- explain the evolution of that policy including the negative factors of and serious harm caused by such a relationship.

CME Credit: 1

■ 3:00 pm – 5:00 pm Identification and Treatment of the Substance-Abusing Patient

Speaker: Kevin S. Ferentz, M.D., Assistant Professor of Family Medicine, University of Maryland; Director, Student and Employee Health

Objectives: Participants will be able to

- understand the positive and effective role primary care physicians have in treating substance-abusing patients,
- recognize and understand how to use several easy to use substance abuse screening questionnaires and laboratory tests used to assess alcohol and drug problems, and
- describe some techniques and strategies for counseling patients with substance abuse problems.

CME Credit: 2

■ 5:15 pm – 6:15 pm **UPDATE:** How to Help Your Patients Stop Smoking

Speaker: Kevin S. Ferentz, M.D., Assistant Professor of Family Medicine, University of Maryland; Director, Student and Employee Health

Objectives: Participants will be able to

- identify and use strategies and techniques to encourage patients to stop smoking, and
- explain the benefits/consequences of prescribing nicotine (gum, patches, etc.) to patients.

CME Credit: 1

The Medical and Chirurgical Faculty is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

The Medical and Chirurgical Faculty designates this continuing medical education activity for up to 7.5 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

This program has been reviewed and is acceptable for 7.5 prescribed hours by the American Academy of Family Physicians

This schedule is preliminary. Times, speakers and topics are subject to change.

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Third Annual Conference on Addiction: Physician Health & Education

Registration Form

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☐ Physician nonmembers/PhDs – \$100
☐ Allied Health Professionals – \$25
☐ Students and Residents – NO CHARGE

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Please indicate your breakout session preference: (refer to schedule for topic)

10:15 a.m. – 11:15 a.m.

☐ A

☐ B

☐ C

A Clinical Moment with . . . Diabetes

Motor-sensory neuropathy

Doctor, I have had type 2 diabetes for the past ten years. I have not monitored my sugar too closely, but I have felt well and have had no problems. Recently I have developed severe pain in my right leg, particularly in the thigh. Nothing I do makes it better or worse, and the pain is severe. I have also noticed that my leg is weak, and I have trouble going up stairs. What is the problem? Is this a complication of diabetes?

Although it is not possible to make a diagnosis based on such a history, the description given is of a symptom complex very common to diabetics. The symptoms described are those of a mixed motor-sensory neuropathy. You are complaining of pain in the thigh that is not positional or related to movement, suggestive of damage to sensory fibers and leg weakness, particularly of hip flexors, which points to damage to a motor nerve. Several possibilities exist to explain these symptoms. One of these is nerve root compression related to back arthritis or disc disease. Most non-insulin dependent diabetes (NIDD, commonly called type 2) patients are overweight, are over age 40, and are at risk for lumbar spine problems. However, weight-bearing activities such as sitting or standing tend to worsen symptoms due to lumbar disease. More likely is the development of a mononeuropathy generally called amyotrophy.

This condition most often occurs in patients with NIDD under poor control. It is by definition asymmetrical but can occur in both legs at different times. The typical symptoms are those you describe. Physical findings usually consist of wasting of the thigh muscles, with obvious weakness, loss of the knee reflex, and possible hypesthesia in the anterior thigh. These patients also often have peripheral neuropathy.

There are no specific diagnostic tests for this condition. It may be important to rule out lumbar spine disease with appropriate x-rays. Nerve conduction studies and electromyograms are not always diagnostic. The diagnosis is primarily a clinical one.

There is no specific treatment for amyotrophy. The presumed cause is microvascular disease in the vessels supplying the femoral or sciatic nerves, resulting in nerve ischemia. Whatever the cause, the usual result is a gradual return to normal function after three to six months. The physician's role in treating this condition is to support the patient through the illness with pain medication and physical therapy to strengthen weakened muscles and keep other muscles active. Improving blood glucose may also be helpful in shortening the duration of the neuropathy.

JAMES H. MERSEY, M.D.
Editor

■

Miscellaneous meetings

- Traditional Chinese medicine**, sponsored by the Baltimore City Medical Society, at Harbor Hospital Center, Baltimore, MD. 1 Cat 1 AMA/PRA credit; 1 AAFP prescribed hour. Fee: none. Info: Lorraine Wallace, 410-625-0022. **Oct. 1**
- New techniques and concepts in cardiology**, sponsored by the American College of Cardiology, at the Hyatt Regency Hotel, Washington, DC. 16 Cat 1 AMA/PRA credits. Info: Registration Secretary, 800-257-4739. **Oct. 22-23**
- Sixth annual national disability management conference and exhibit**, sponsored by the Washington Business Group on Health (WBGH), at the Crystal Gateway Marriott, Arlington, VA. Fee: \$400 WBGH members; \$475 nonmembers. Info: 202-408-9320. **Oct. 26-27**
- The African-American perspective on substance abuse**, sponsored by the Monumental City Medical Society, the Baltimore City Health Department, and the Baltimore Substance Abuse Systems, Inc., at the Stouffer Harborplace Hotel, Baltimore, MD. 7 Cat 1 AMA/PRA credits. Fee: \$75. Info: 410-396-1589. **Nov. 7**
- Sixteenth annual symposium on computer applications in medical care**, sponsored by the American Medical Informatics Association, at the Baltimore Convention Center, Baltimore, MD. Fee: \$505. **Nov. 8-11**
- International standards update**, sponsored by the Association for the Advancement of Medical Instrumentation, in Washington, DC. Info: 703-525-4890, ext. 212 or 210. **Nov. 7**
- Arthritis care for the 1990s: A practical approach for the primary care physician**, sponsored by the Arthritis Foundation, Maryland Chapter, at the Sheraton Inner Harbor Hotel, Baltimore, MD. 5 Cat 1 AMA/PRA credits. Fee: \$45, \$30 if not requesting CME. Info: Karen Krug, 561-8090 or 800-365-3811. **Nov. 14**
- Third annual conference on addiction: Physician health and education**, sponsored by the Medical and Chirurgical Faculty of Maryland, at the Faculty Building, Baltimore, MD. 7.5 Cat 1 AMA/PRA credits. Fee: \$50 Med Chi members; \$25 physician nonmembers and PhDs; \$25 allied health professionals; No charge for students and residents. Info: Vivian Smith, 410-539-0872 or 1-800-492-1056. **Nov. 21**
- Williamsburg conference on heart disease**, sponsored by the American College of Cardiology at the Williamsburg Conference Center, Williamsburg, VA. 18 Cat 1 AMA/PRA credits. Info: 800-257-4739. **Dec. 6-9**
- Cardiovascular science and technology conference**, sponsored by the Association for the Advancement of Medical Instrumentation, Washington, DC. Info: 703-525-4890, ext. 210 or 212. **Dec. 12-14**
- Maryland Academy of Family Physicians first semiannual meeting**, at the Hyatt Regency Inner Harbor Hotel, Baltimore, MD. 10 Cat 1 AMA/PRA credits; 10 AAFP prescribed hours. Fee: \$100 MAFP members; \$150 nonmembers; \$60 paramedicals; No charge for residents, medical students, and MAFP life and retired members. Info: William P. Jones, M.D., 410-747-1980. **Jan. 30-31, 1993**

Continuously throughout the year

- Fluorescein angiography conference**, sponsored by the Retina Center, St. Joseph Hospital, Baltimore, MD, first and third Mondays of each month; 8:00-9:00 a.m. Fee: none. Info: R. Classon, 410-337-4500.

Shady Grove Adventist Hospital,

9901 Medical Center Drive, Rockville, MD. Info: 301-279-6115.

Special considerations for the elderly arthritic patient.

Oct. 1

Update on discharge planning services.

Oct. 8

The retina.

Oct. 29

Risk management.

Nov. 5

Diabetes.

Nov. 12

PHYSICIAN PLACEMENT SERVICES

The Medical and Chirurgical Faculty of Maryland maintains a Placement Service for the convenience of Maryland physicians, hospitals, and communities in search of candidates for positions available in our state. A detailed description of such opportunities should be forwarded to:

*Physician Placement Service
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Physicians wishing to locate in Maryland are invited to submit a resume to be kept on file with the Physician Placement Service. Candidates are requested to inform the Faculty when they are no longer available for consideration for opportunities in Maryland.

MMJ announcements for physician placements in the Classified Advertisements are charged at the regular Classified Advertising rate.

The Johns Hopkins Medical Institutions

All courses at the Turner Auditorium unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Education, 720 Rutland Ave., Baltimore, MD 21205 (410-955-2959).

- 34th annual Emil Novak memorial course: Gynecology, gynecological pathology, endocrinology, and high-risk obstetrics.** 53 Cat 1 AMA/PRA credits; 51 ACOG cognates. Fee: \$675 physicians; \$475 residents, fellows, and allied health professionals. Oct. 12-17
- Core content of emergency medicine: A comprehensive review,** at the Marriott Hotel, Baltimore-Washington International Airport, Baltimore, MD. Cat 1 AMA/PRA credits and ACEP credits available. Fee: \$1,000; \$75 ultrasound workshop; \$125 computer lab; \$75 wound closure/care lab. Oct. 17-23
- Diabetic retinopathy.** 8 Cat 1 AMA/PRA credits. Fee: \$200 physicians; \$100 residents, fellows, and allied health professionals. Oct. 23
- Update on sinusitis for the practitioner.** 9 Cat 1 AMA/PRA credits. Fee: \$175 physicians; \$95 residents, fellows, and allied health professionals. Oct. 30
- Hemodynamic monitoring, patient care and pulmonary artery catheterization—A hands-on course.** 14 Cat 1 AMA/PRA credits. Fee: \$575. Oct. 31-Nov. 1
- Advanced pediatric life support courses.** 20 Cat 1 AMA/PRA credits. Fee: TBA. Nov 2-4
- Progress in pediatrics.** 11 Cat 1 AMA/PRA credits. Fee: \$140 physicians; \$80 residents, fellows, and nurse practitioners. Nov. 6-7
- Horizons in transplantation.** 6.5 Cat 1 AMA/PRA credits. Fee: \$45. Nov. 13
- Neural mechanisms of the auditory and vestibular systems II.** Cat 1 AMA/PRA credits available. Fee: \$375 physicians; \$300 residents and fellows; \$450 allied health professionals. Dec. 1-2
- Clinical management of vestibular disorders.** Cat 1 AMA/PRA credits available. Fee: \$375 physicians; \$300 residents and fellows; \$450 allied health professionals. Dec. 3-4
- The Wilmer Ophthalmological Institute's current concepts in ophthalmology.** 20 Cat 1 AMA/PRA credits. Fee: \$300 physicians; \$250 residents, fellows, and allied health professionals. Dec. 10-12
- Endoscopic sinus surgery.** 19 Cat 1 AMA/PRA credits for lab and lectures; 14.5 Cat 1 AMA/PRA credits for lecture only. Fee: \$1,250 for laboratory and lectures; \$295 for lecture series only. Jan. 7-8
- Advanced endoscopic sinus surgery.** 9 Cat 1 AMA/PRA credits. Fee: \$1,050. Jan. 9, 1993
- 1993 update in the management of age-related macular degeneration.** 6.5 Cat 1 AMA/PRA credits for one-day course; 8.5 Cat 1 AMA/PRA credits for two-day course. Fee: \$200 physicians; \$100 residents, fellows, and allied health professionals; \$350 lectures and optional lab course. Jan. 22-23, 1993
- 34th annual postgraduate institute for pathologists in clinical cytopathology.** Course A: Home study, March-April 1993. Course B: Lecture series with laboratory studies. 140 Cat 1 AMA/PRA credits. Apr. 19-30, 1993
- PET and SPECT imaging of living brain chemistry.** 18 Cat 1 AMA/PRA credits. Fee: \$495 physicians; \$395 residents, fellows, and allied health professionals. Mar. 10-12, 1993
- Principles and practice of clinical MRI,** at the Stouffer Harborplace Hotel, Baltimore, MD. Cat 1 AMA/PRA credits available. Fee: TBA. Apr. 22-25, 1993

Continuously throughout the year

Visiting preceptorship in pediatric critical care medicine. Ongoing five-day preceptorship by appointment. 40 Cat 1 AMA/PRA credits. Fee: \$600.

The department of radiology and radiological sciences offers several courses in abdominal and obstetrical ultrasound. Info: P. Williams, 410-955-3169.

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Johns Hopkins medical grand rounds. Accredited audiovisual continuing education series of case discussions for clinicians; thirty topics per year in five bimonthly programs. Individual and group subscriptions. 40 Cat 1 AMA/PRA credits. Info: 410-955-3988.

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For each course, additional information may be obtained by contacting the Program of Continuing Education, University of Maryland School of Medicine, Room 14-011, BRB, 655 W. Baltimore St., Baltimore, MD 21201 (410-328-3956) or by calling the phone number listed after a specific program. FAX 410-328-3103.

- | | |
|--|-------------------------|
| Role of outcomes research in the reformed health care system , at the Marriott Inner Harbor Hotel, Baltimore, MD. 17.5 Cat 1 AMA/PRA credits. Fee: \$240. Info: Charlene Quinn, 410-328-6086. | Oct. 4-6 |
| New strategies in smoking cessation , at the Stouffer Harborplace Hotel, Baltimore, MD. 4.5 Cat 1 AMA/PRA credits. Fee: \$50. | Oct. 10 |
| 8th annual contact lens symposium , at the Turf Valley Conference Center & Country Club, Ellicott City, MD. 12 Cat 1 AMA/PRA credits. Fee: \$195. Info: Carol Shaner, 410-727-7800. | Oct. 17-18 |
| HIV counseling skills I , sponsored by the Maryland AIDS Professional Education Center, in Annapolis, MD. Info: Gwen Kergides, 410-328-8639. | Oct. 19-22 |
| Infectious disease update: Diagnosis and treatment of commonly acquired infections , at the Hyatt Regency Hotel, Baltimore, MD. 7 Cat 1 AMA/PRA credits. Fee: \$25. | Oct. 22 |
| AIDS: A challenge to primary care—4th annual symposium , sponsored by the Maryland AIDS Professional Education Center, at the Baltimore Convention Center, Baltimore, MD. 12 Cat 1 AMA/PRA credits. Fee: \$200 physicians; \$125 other health professionals; \$50 residents, fellows, and students. Info: Jonathan A. Cohn, M.D., 410-328-2792 or Carol Kowarsky, 410-328-3767. | Oct. 26-27 |
| Infectious disease update: Diagnosis and treatment of commonly acquired infections , at the Sheraton Hagerstown Conference Center, Hagerstown, MD. 6 Cat 1 AMA/PRA credits. Fee: \$25. | Nov. 5 |
| Epilepsy today and tomorrow: What, why, when, and how , at the Harbor Court Hotel, Baltimore, MD. 5 Cat 1 AMA/PRA credits. Fee: \$65. Info: Diana Roche, 410-242-7300. | Nov. 13 |
| HIV Advanced Counseling Skills II , sponsored by the Maryland AIDS Professional Education Center, in Hagerstown, MD. Info: Gwen Kergides, 410-328-8639. | Nov. 19-20 |
| The Maurice C. Pincoffs lecture in medicine , in Davidge Hall, UMAB campus. 1 Cat 1 AMA/PRA credit. Fee: none. Info: Theodore E. Woodward, M.D., 410-328-6070. | Dec. 7 |
| HIV Counseling Skills I , sponsored by the Maryland AIDS Professional Education Center, in Baltimore, MD. Info: Gwen Kergides, 410-328-8639. | Dec. 8-11 |
| Advanced trauma life support , sponsored by the Maryland Institute for Emergency Medical Services Systems, in Baltimore, MD. Info: Office of International Development, 410-328-2399. | Mar. 10-11, 1993 |
| Managed care and quality improvement: Making a difference , sponsored by the Maryland Institute for Emergency Medical Services Systems, in Baltimore, MD. Info: Office of International Development, 410-328-2399. | Mar. 11, 1993 |
| Alcohol and trauma care , sponsored by the Maryland Institute for Emergency Medical Services Systems, in Baltimore, MD. Info: Office of International Development, 410-328-2399. | Mar. 11, 1993 |
| R. Adams Cowley 15th national trauma symposium , sponsored by the Maryland Institute for Emergency Medical Services Systems, at the Hyatt Regency Baltimore, in Baltimore, MD. Info: Office of International Development, 410-328-2399. | Mar. 12-14, 1993 |

Continuously throughout the year

Visiting professor program. A directory of speakers and their topics is available to area hospitals and other health care organizations. NO administrative fees are charged for this service. Info: 410-328-3956.

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During July and August 1992, the physicians listed below received the American Medical Association's (AMA's) Physician's Recognition Award. Established in 1968, the award's purpose is to encourage physician participation in continuing medical education and to recognize those physicians who have voluntarily completed programs of continuing medical education.

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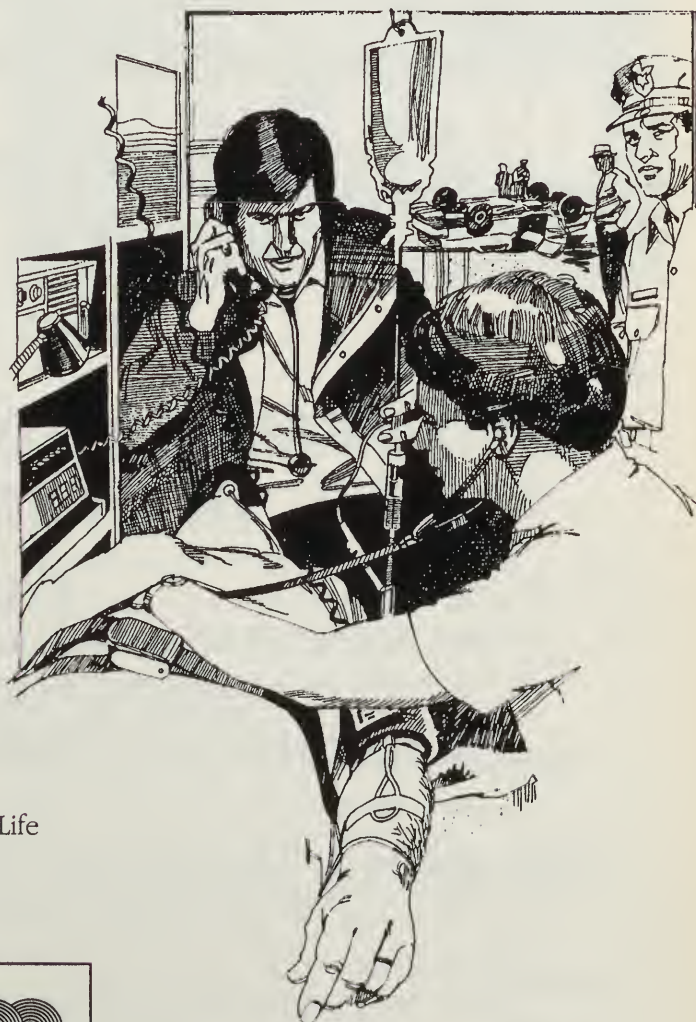
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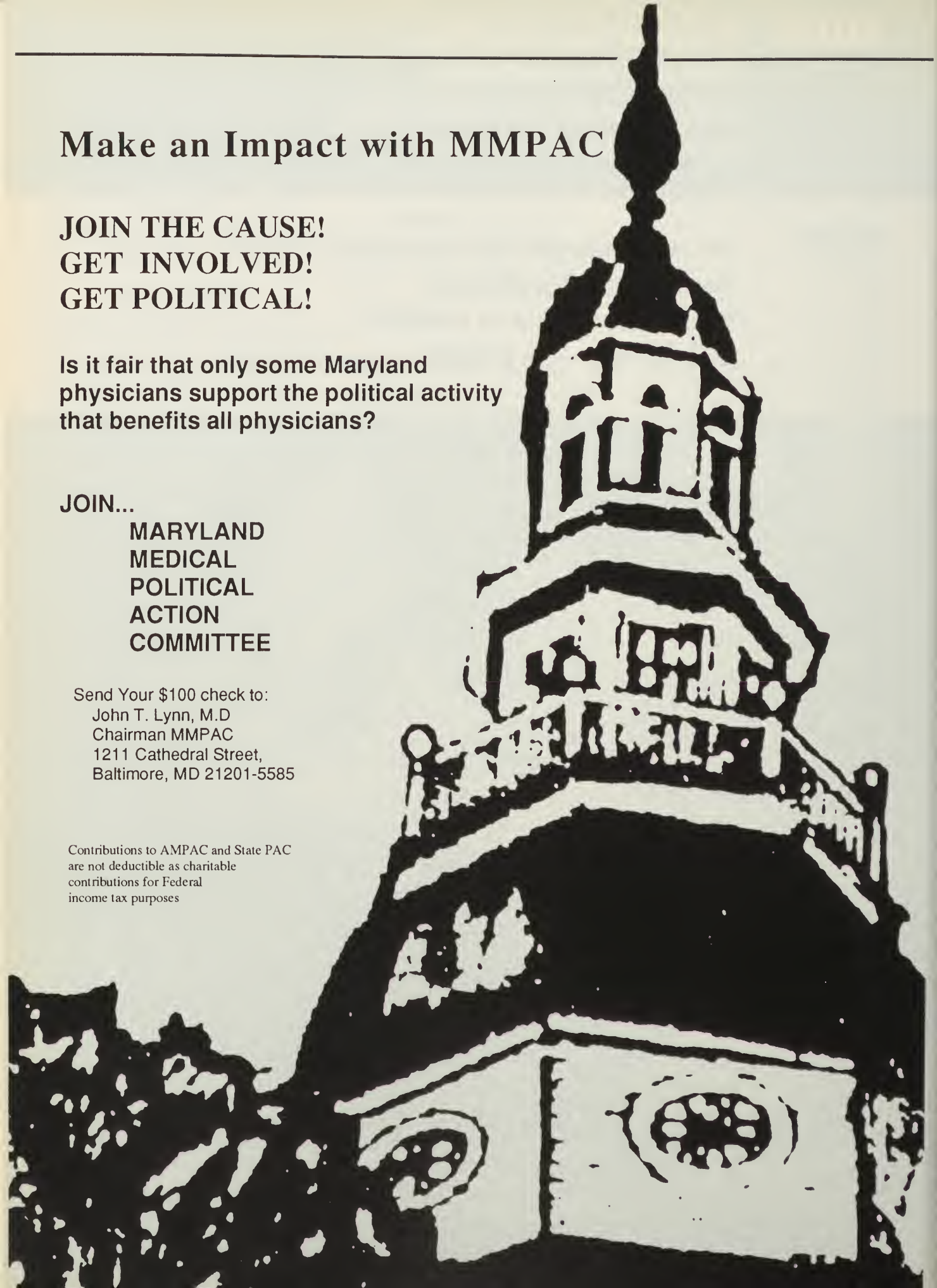
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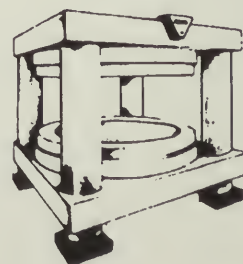
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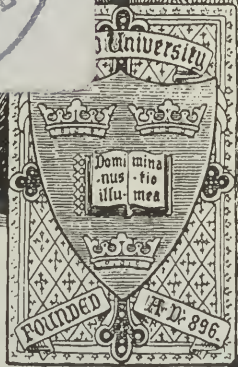
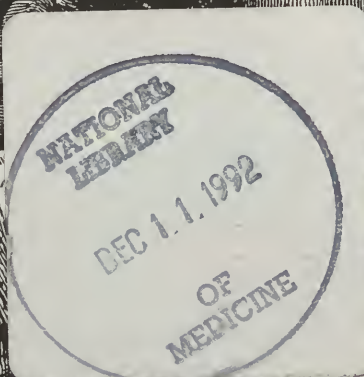
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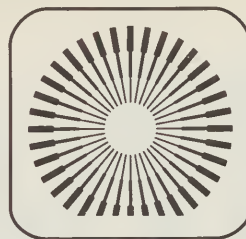


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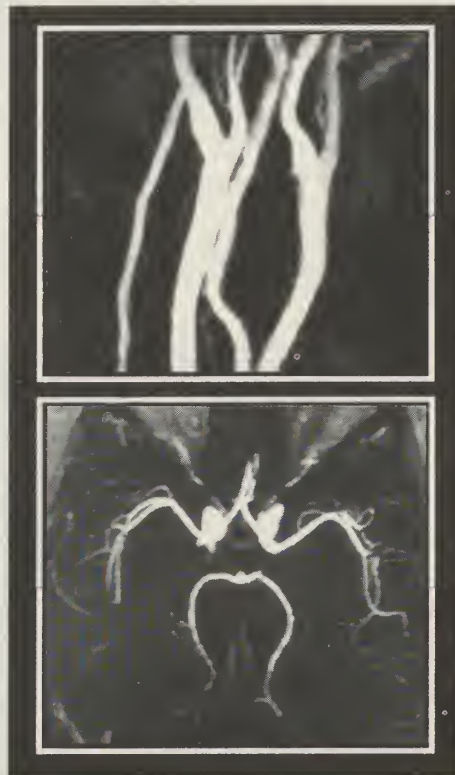


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FIGURE 1



FIGURE 2

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Maryland Medical Journal

NOVEMBER 1992

VOLUME 41 NO 11

- Frank A. Gunther, Jr.: Chairperson of the Board of Directors of Blue Cross and Blue Shield of Maryland—
An interview with the editor 967**

Betsy Newman

Following allegations of mismanagement by the US Senate Subcommittee on Permanent Investigations, Frank Gunther, Jr. replaced Carl Sardegna as chairperson of the Board of Directors of Blue Cross and Blue Shield of Maryland. Editor Victor R. Hrehorovich, M.D. questioned Mr. Gunther about the charges and his vision of BCBSM's future.

- Physician estimates of substance abuse in Baltimore and Cumberland: 1991 973**

Carmine M. Valente, Ph.D.; Karen R. Duszynski, B.A.; Roland T. Smoot, M.D.; Kevin Scott Ferentz, M.D.; David M. Levine, M.D., Sc.D.; and Angelo J. Troisi, F.A.C.H.E.

By identifying and counseling substance abusers within their own practices, primary care physicians can play a major role in reducing levels of substance abuse. How proficient area physicians are in identifying substance abuse is examined by comparing physician estimates of substance abuse in their patient populations with local and national statistics.

- Functional improvement in geriatric trauma patients
admitted to a dedicated rehabilitation hospital 981**

Marilyn Radke, M.D., M.P.H.; James P.G. Flynn, M.D.; Maura Smith, M.D.; Jean C. Scott, Dr.P.H.; and Thomas Permutt, Ph.D.

A retrospective study was undertaken of trauma patients over 55 years of age who were admitted to a rehabilitation hospital during an 18-month period. Significant risk factors for poorer in-hospital improvement in functional independent measures were male sex, having an offspring listed as next of kin, pre-injury diabetes mellitus and/or dementia, and number of comorbidities. Being married was found to be protective.

- Ophthalmomyiasis externa: A case report 989**

Marcos T. Doxanas, M.D.; J. Ronald Walcher, M.D.; and Rebecca A. Ludwig, M.D.

A three-year-old white male presented with an extremely painful abscess of the nasal portion of the right upper eyelid. A larva identified as family cuterebridae, genus *Cuterebra* sp, was removed from the abscess, permitting its rapid resolution. This represents an unusual patient with external ophthalmomyiasis who enjoys excellent nutritional and environmental surroundings.

MEDICAL HISTORY

- Two centuries of medical organization and licensure in Maryland 993**

Joseph M. Miller, M.D.

In 1766, the first American medical society was established in New Jersey. It was not until 1968, more than 200 years later, that the state medical societies would finally mold a satisfactory means of medical qualification and licensure.

- Sir William Osler—Contrasts between the saint-like legend and the rough-edged man 997**

Perry Hookman, M.D., M.H.A., F.A.C.G., F.A.C.P.

Sir William Osler, the first physician-in-chief of the Johns Hopkins Hospital and later Regius Professor of Medicine at Oxford, is judged by many to be the greatest clinician of the modern era. His life history of distinguished service to medicine and to society is well known. What is not so well known is his mischievous streak.

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Cover: Max Brödel—a review of whose biography is on page 1025—designed the bookplate depicted on the cover. It was made in 1919 when a committee headed by Dr. Charles Brack gave Med Chi \$10,000 for the purchase of books for the library and the care of Osler Hall. (See "Letters to the Editor" on page 964 for information on a new library endowment fund.)

The pen and ink bookplate shows Aesculapius (also portrayed on Med Chi's logo) surrounded by insignias of McGill, the University of Pennsylvania, Oxford, and Johns Hopkins—institutions with which Osler was intimately affiliated. (Osler's life is discussed in an article beginning on page 997.) Cover Design: Susan Ventura

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BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents.

References: 1. Data on file, Searle. 2. Edmonds D, Würth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calcium antagonist therapy. In: Fleckenstein A, Laragh SH, eds. *Hypertension—the Next Decade: Verapamil in Focus*. New York, NY: Churchill Livingstone; 1987:94-100. 3. Midtbø KA. Effects of long-term verapamil therapy on serum lipids and other metabolic parameters. *Am J Cardiol*. 1990;66:131-151. 4. Fagher B, Henningsen N, Hulthén L, et al. Antihypertensive and renal effects of enalapril and slow-release verapamil in essential hypertension. *Eur J Clin Pharmacol*. 1990;39(suppl 1):S41-S43. 5. Schmieder RE, Messerli FH, Garavaglia GE, et al. Cardiovascular effects of verapamil in patients with essential hypertension. *Circulation*. 1987;75:1030-1036. 6. Midtbø K, Lauve O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. *Angiology*. 1988;39:1025-1029.

Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°, 2°, 3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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TOUGH, SMART AND YOURS

medical
economics
A P-I-E BOOK

Successfully defending a brain-damaged baby case is the courtroom equivalent of pitching a no-hitter. Because the "sympathy factor" can add millions to a jury's award, many insurance carriers would rather settle than fight.

Not so the P-I-E Mutual Insurance Co. of Cleveland, Ohio, and the 4-year-old law firm—Jacobson, Maynard, Tuschman & Kalur—that does all its defense work. In 21 brain-damaged baby cases it has defended for the doctor-owned company, its record is a remarkable 19-1, the last a hung jury. In 1988, its overall success record of 41 wins, 3 losses—all malpractice cases.

There's more to those numbers than luck. "Or even legal skill," adds JMT&K founding partner Aaron Jacobson, who was one of Ohio's leading plaintiff lawyers before he, Larry E. Rogers, Herbert S. Bell, M.D., and 70 other Cleveland doctors formed P-I-E in 1977.

It's the concept behind the firm that makes it work. Physicians specialty panels review every lawsuit to decide whether the defendant deviated significantly from the standard of care. If he did, we pay. If he didn't, we defend. Makes no difference whether it's a \$5,000 or a \$5 million case. We label it "No pay." That policy has resulted in a lot of cases being dropped. Perhaps more important, it's

DON'T YOU WISH THESE DEFENSE LAWYERS WERE YOURS?

This big, multistate firm rarely loses a case. But it's more than luck, or even legal skill, that's behind its enviable record.

By Howard Eisenberg

discouraged the filing of many other cases. Plaintiffs' attorneys have learned that we're fair negotiators when our doctors are in the wrong, but won't back down when he's right.

That approach pays off. "According to the most recent report I've seen from the General Accounting Office," says Larry Rogers, P-I-E president and CEO, "in 1984, about 57 percent of medical malpractice claims were closed without payment. Through 1988, we've closed an average of 78 percent of our cases without a dime changing hands. And it's my understanding that, without including defense costs, St. Paul Fire and Marine Insurance Co.'s 1988 average gross payout for cases closed in Ohio with payment was \$52,500. Our comparable figure was about \$10,000 below

theirs. That's partly why we ran sell an OBG specialist in Ohio—an industrial state that ranks among the most litigious—\$12 million in coverage for just \$26,400."

The unique marriage of P-I-E and JMT&K has been so successful that the carrier has expanded into five other states—Indiana, Kentucky, Maryland, Missouri, and West Virginia. Where P-I-E goes, there goes JMT&K, with nine branch offices to date. The firm has 60 trial attorneys, and may well be the nation's largest devoted exclusively to medical malpractice defense.

Could the insurer-defender symbiosis, if duplicated by other doctor companies, make a significant contribution to reducing malpractice litigation nationwide? An up-close look at

how JMT&K operates may help to answer that question.

Every lawyer develops a medical specialty

"Our firm's lawyers read more medical books than law books," says P-I-E Vice President Gerard C. Oppenorth, himself a veteran defense attorney. Robert Maynard explains, "New cases are discussed at our weekly staff meeting, so that every lawyer is familiar with every case. But we assign cases to our attorneys according to medical specialty. They're well-versed in their fields, so they don't have to reinvent the wheel with each case."

Last year, the firm's OBG specialist, attorney Jerome S. Kalur, who had won 10 consecutive brain-damaged baby cases, faced one of his toughest challenges when he defended a GP

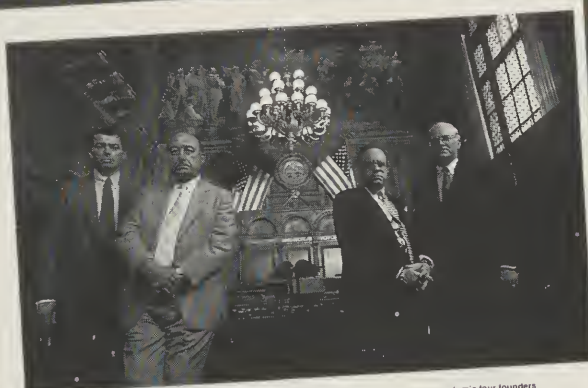
who'd attempted a midforceps delivery that ended in a Cesarean section and a severely brain-injured baby. Recalls Kalur, "I didn't think the doctor had caused the damage, but our position was weakened by the fact that he didn't have midforceps privileges. Based on that departure from the standard of care, our doctor panel voted to settle, and, since the hospital was also involved, a combined sum of \$1.5 million was offered. Plaintiffs turned us down flat."

"I wanted to depose the doctors who'd been involved in the mother's care during her hospitalization, but the attorney for the plaintiff baby insisted it would violate the mother's physician-patient confidentiality. That privilege would terminate automatically when her medical

The winning firm's four founders at Cleveland's 6th District Court of Appeals (from left): Jerome S. Kalur, Aaron Jacobson, James M. Tuschman, and Robert Maynard

records were introduced at the trial end of the plaintiff's case. Meanwhile, I was in the new position of having to tell the jury, 'It couldn't have been the midforceps,' without offering them another reasonable brain damage theory."

Fortunately, the plaintiffs rested their case on a Friday afternoon, giving JMT&K time for a weekend rally. "Twenty minutes later," says Kalur, "I was in the hospital pathologist's office with an order permitting me to view the mother's placental slides." Meenuum staining had been charted, and Kalur had a hunch that fetal distress had begun long before the for-



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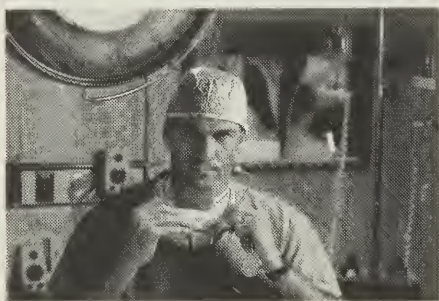
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*DHMH Programs for
Breast and Cervical
Cancer*

The Maryland Department of Health and Mental Hygiene (DHMH) is involved in several activities related to the early detection and treatment of breast and cervical cancer among low income, uninsured women in Maryland: (1) a program that will pay private physicians to provide breast and cervical cancer screening to eligible women, (2) a program that will pay private physicians Medicare rates to provide breast and cervical cancer diagnosis and treatment to eligible women, and (3) a media campaign to encourage women to get ongoing breast and cervical cancer screening. These programs are described below.

1. In January 1992, DHMH received a Breast and Cervical Cancer grant from the federal Centers for Disease Control. The grant is four years, seven months in length, and the award is \$3 million per year for a total of \$15 million dollars. The purpose of this grant is to increase breast cancer and cervical cancer screening levels among uninsured and low income women statewide, to provide follow-up to diagnosis and treatment, to carry out public and professional education, to assure the quality of screening activities, to conduct surveillance, and to carry out evaluation of these programs.

Grants are being awarded to each of the 24 local health departments in the state to coordinate the provision of outreach, patient/public education, screening, referral, and follow-up services. Each local health department will be entering into contracts with private physicians to provide clinical and laboratory services. Over 60% of the total grant funds must be used to pay for direct clinical services.

Grant funds may be used to pay for screening mammography (maximum of \$56.76), diagnostic mammography, clinical breast examination, Pap smear, pelvic examination, colposcopy, and lab fees to pay for reading Pap smears and cervical biopsies.

2. Funding has also become available, under the governor's cancer initiative, to pay for breast and cervical cancer diagnosis and treatment for low income, uninsured women in the state. DHMH is developing regulations for this program and will pay physicians the currently approved Medicare rate to provide these services to eligible women. Physicians will be asked to complete an application form to become a participating provider under this program. Any physician in Maryland interested in discussing possible involvement with any of these two programs should call Dr. John Southard, from DHMH, at 410-225-6778.
3. DHMH is also developing a Maryland cancer control marketing campaign that will focus on tobacco prevention and cessation and

the early detection and treatment of breast and cervical cancer. The campaign will be statewide and will involve both mass media (i.e., TV, radio, newspaper) as well as local intervention efforts. The campaign is expected to kick off in mid-November. For more information, call Marsha Bienia, from DHMH, at 410-225-6787.

*Change in dates for 1993
Annual Meeting*

On November 19, the Med Chi Council voted to extend the 1993 Med Chi Annual Meeting to three days. The meeting will now be Thursday, Friday, and Saturday, April 29, 30, and May 1, 1993 at the University of Maryland, University College Conference Center in College Park.

*Call for Papers—1993
Annual Meeting*

"Prevention 1993—Maryland" is the theme for the 1993 Med Chi Annual Meeting. Preventive care will be the focus for continuing medical education programs at the meeting. Med Chi invites papers dealing with subjects related to this topic for consideration by the Committee on Scientific Activity. For more information, call Med Chi's Office of Continuing Medical Education at 410-539-0872 or 1-800-492-1056.

*Physician Disclosure of
Ownership in Health
Care Services*

As a continuing service to its members, Med Chi publishes signs to help physicians comply with current law. Since July 1, 1991, Maryland law requires physicians to post a notice in their offices regarding their ownership of health care services to which they refer patients. Posting the disclosure of ownership sign that follows this newsletter will help physicians comply with this law. A copy of the law (Section 10-206 of the Health Occupations Article of the Annotated Code of Maryland) appears on the reverse side of the sign. Additional signs may be obtained by calling Med Chi's Communications Department at 410-539-0872 or 1-800-492-1056.

*AMA Health Access
America Slide
Presentation*

The AMA recently produced a 30-minute slide presentation on Health Access America. This presentation is available for physicians who wish to lead a substantive discussion, with colleagues or with community groups, on health care reform. Med Chi is loaning the slides to interested physicians. If you know a group that would like a Health Access America presentation or if you are interested in becoming a Health Access America presenter, please contact Betsy Newman in Med Chi's Communications Department at 410-539-0872 or 1-800-492-1056.

*Performing Arts
Medicine Conference*

"Performing Arts Medicine II: Focus on Young Performers," is a conference on the special problems of performing artists scheduled to be held March 20-21, 1993 at the Med Chi Faculty Building, 1211 Cathedral Street, Baltimore. Sponsored by Med Chi's Committee on Medicine and Performing Arts, this conference is scheduled to include discus-

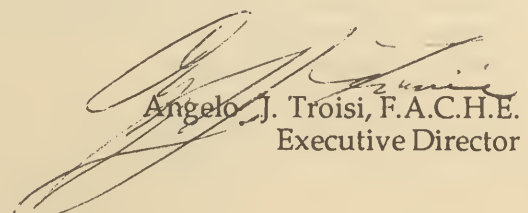
sions on focal dystonia, eating disorders, Alexander and Feldenkrais techniques, drug side effects, conditioning and physical fitness, problems of marching musicians, and implications of the Americans with Disabilities Act. Watch the *Maryland Medical Journal* for more information about this upcoming conference.

"Dear Doctor" Column

The Public Relations Committee is gathering articles by physicians to include in a "Dear Doctor" column that will be published in various Maryland newspapers. The committee is currently recruiting additional physician volunteers to write articles for this column. Requirements for the articles in the column are as follows:

1. Articles should be written in a question-and-answer format—write as though a patient has just asked you a question. (e.g., Question: What causes the common cold? Answer: There are a number of viruses that can cause a cold...);
2. Articles should be about a subject that is both interesting to the general public and timely;
3. Articles should be written in layperson's terms—try to avoid medical jargon; and
4. Articles should be between 250 and 500 words in length.

All articles submitted for this project will be reviewed by the Public Relations Committee. Since the committee would like to have the "Dear Doctor" column appearing in area newspapers this spring, column submissions will be accepted until February 15, 1992. For questions or more information about the "Dear Doctor" column, contact Betsy Newman or Vivian Smith in the Communications Department at 410-539-0872 or 1-800-492-1056.



Angelo J. Troisi, F.A.C.H.E.
Executive Director



President's Memo

Prepared by the president of the Medical and Chirurgical Faculty of Maryland as a service to members

Date: October 8, 1992
To: Med Chi Members
From: President Jose M. Yosunico, M.D.
Re: InforMed (Barton-Gillet) Physician Services

Over the past several months, Med Chi has received numerous inquiries from physicians asking the Faculty if it endorsed InforMed Physician Services, Barton-Gillet Physician Services, or the new select/preferred provider programs offered by Blue Cross/Blue Shield of Maryland (BCBSM). It has never been the policy of Med Chi to endorse any third-party payer. Whether or not a physician decides to participate in a particular insurance program is an economic decision that must be made by each individual physician. Med Chi does not endorse or recommend any specific insurance program.

In December 1991, Med Chi signed an agreement with Barton-Gillet Physician Services, Inc. that assured "continued confidentiality and proper use of the physician practice data under Maryland law in the event that a physician requests that Med Chi disclose his or her identifier." This agreement was intended to protect the disclosure of individual physician information so that the information would not be used to "pressure physicians into altering practice patterns in a manner that could adversely affect the quality of patient care." The agreement also provided for Barton-Gillet to "use aggregate data that does not identify any individual physicians to demonstrate to third-party payers that the physicians participating in Barton-Gillet's program are cost-effective providers of quality care."

On December 31, 1991, Med Chi wrote a letter to David W. B. Willse, president, Barton-Gillet Physician Services, referencing the agreement signed with Barton-Gillet and stating that Med Chi staff would release the ghost numbers of physicians who authorize Barton-Gillet to represent them in establishing contracts with third-party payers. This letter was used, without Med Chi's permission, in a mailing to physicians from BCBSM to solicit physician participation in its programs. When this situation was made known to the Faculty, both InforMed and BCBSM were contacted and asked to cease and desist this practice. (BCBSM has complied with that request and no longer includes the Med Chi letter in its solicitation.)

At the current time, Med Chi will only release the physician's ghost number (that number which is assigned to every practicing physician in Maryland and allows access to hospital practice information collected by the Health Services Cost Review Commission) if the physician signs an authorization form and requests that Med Chi release this number. Otherwise, this ghost number is kept confidential in accordance with current law. The information obtained by using this ghost number relates to hospital practice patterns; many physicians are presently receiving some of this information from their affiliate hospitals at no cost to the physician.

It has been demonstrated that practice patterns of peers and practice-parameter (guideline) awareness has been effective in addressing increased efficiency and cost containment without sacrifice in the quality of care.

InforMed is a private enterprise that has entered into an agreement with BCBSM to market a cost-contained program enhancing BCBSM's competitiveness in the marketplace. It is up to the individual physician whether or not he or she wants to use the services provided by InforMed, Barton-Gillet, or any other similar organization.



Medical and Chirurgical Faculty of Maryland

President's Letter

Prepared by the president of the Medical and Chirurgical Faculty of Maryland as a service to members

Dear Colleague:

Due to the recession and the government's budget deficit, the state of Maryland recently was forced to cut \$50.2 million from the state's medical assistance programs for the poor. It is estimated that 30,000 of our state's Medicaid clients who do not qualify for federal aid will not receive benefits. In addition, local health departments will lose \$15.1 million.

In response to these cuts, the Council of the Medical and Chirurgical Faculty of Maryland (Med Chi) passed the following resolution:

"Therefore, be it resolved that the Medical and Chirurgical Faculty of Maryland take a leadership position in responding to patient needs by making every effort to ensure that each component medical society work in harmony with its respective county/city health department to provide, voluntarily, those specific medical services that are required in its specific geographical area, which will not be available due to the reduction of funding for these programs."

Over the past several months, Med Chi has worked in conjunction with the Maryland Association of County Health Officers (MACHO) and the Department of Health and Mental Hygiene to resolve this issue.

Under the plan, Med Chi and its component medical societies will work with county/city health departments to provide volunteer physicians for needed medical services.

As introduced, the state budget cuts will result in a decrease or total deletion of services such as childhood immunizations, influenza vaccinations, HIV/AIDS counseling, sexually transmitted disease evaluations, ENT examinations, orthopaedic examinations, and a host of other preventive measures. The physicians of the Medical and Chirurgical Faculty of Maryland believe that not providing these preventive measures will ultimately result in higher costs of providing acute care to this population in the future.

Physicians are urgently needed for this volunteer effort. If you are interested in serving as a volunteer for your county/city health department, contact your component medical society for more information. (Phone numbers of component societies are listed on the next page.)

During a time when our nation's health care system is being carefully scrutinized, it is in our best interests to show the public that physicians still provide high quality volunteer medical services to the indigent.

Your cooperation in this effort is greatly appreciated.

Sincerely,

A handwritten signature in dark ink, appearing to read "Jose Yosunico".

Jose M. Yosunico, M.D.
President

Component society**Phone numbers**

Allegany County	301-777-1150
Anne Arundel County	410-544-0312
Baltimore City	410-625-0022
Baltimore County	410-296-1232
Calvert County	301-652-2707
Caroline County	410-822-0697/ 479-2605
Carroll County	410-857-7316
Cecil County	410-398-4000 (ext. 1600)
Charles County	301-934-3626
Dorchester County	410-228-4991
Frederick County	301-698-3458
Garrett County	301-334-8600
Harford County	410-557-6709
Howard County	410-781-6330
Kent County	410-778-3300 (ext. 4060)
Montgomery County	301-921-4300
Prince George's County	301-341-7758
Queen Anne's County	410-758-1363
St. Mary's County	301-475-8066
Somerset County	410-968-1949
Talbot County	410-822-1000
Washington County	301-790-8751
Wicomico County	410-543-7007
Worcester County	410-289-6241

TO MY PATIENTS

When I refer you to a specific health care facility for medical tests or services, you may go to that facility or any other* to have the tests or services completed. As you make this decision, I want you to know that I or members of my immediate family own a business interest in the following health care facilities:

Please feel free to ask me any questions you may have about your care. I am always interested in your continued good health.

Physician's Signature

* (unless you belong to an HMO and your plan requires that you use a particular facility.)



☆ ☆ ☆ **IMPORTANT** ☆ ☆ ☆

***MARYLAND LAW REGARDING NOTICE OF OWNERSHIP
OF OTHER HEALTH CARE SERVICES***

Effective July 1, 1991, Maryland law requires physicians to post a notice in their offices regarding their ownership of other health care services to which the physician refers patients. (see back)

The law, which is outlined in Section 1-206 of the Health Occupations Article of the Annotated Code of Maryland, states in part:

A health care practitioner may refer a patient or direct an employee of the practitioner to refer a patient to a health care service in which the practitioner, the practitioner's immediate family, or the practitioner in combination with the practitioner's immediate family owns a significant beneficial interest, if prior to the referral the practitioner:

(I) Except if an oral referral is made by telephone, provides the patient with a written statement that:

1. Discloses the existence of the ownership of the significant beneficial interest;
2. States that the patient may choose to obtain the health care service from another provider of the health care service; and
3. Requires the patient to acknowledge in writing receipt of the statement;

(II) Except if an oral referral is made by telephone, inserts in the medical record of the patient a copy of the written acknowledgement;

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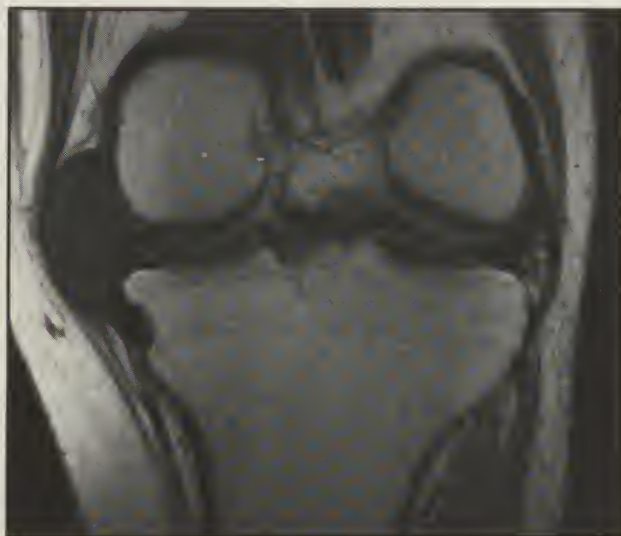
1. In which the practitioner, the practitioner's immediate family, or the practitioner in combination with the practitioner's immediate family owns a significant beneficial interest; and
2. To which the practitioner refers patients; and

(IV) Documents in the medical record of the patient that:

1. A valid medical need exists for the referral; and
2. The practitioner has disclosed the existence of the significant beneficial interest to the patient.



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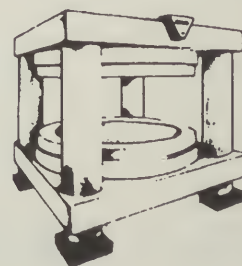
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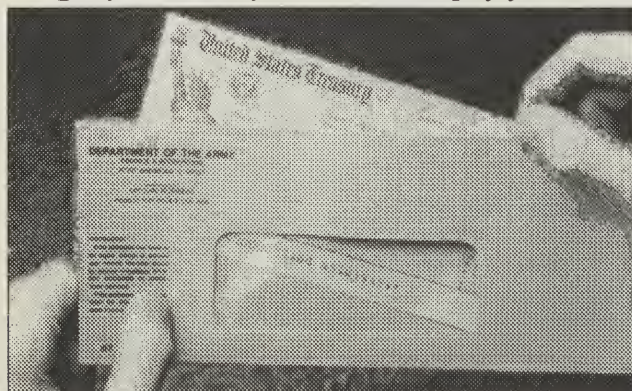


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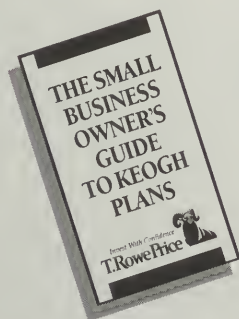
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She came in 1896 as a librarian without knowledge of the medical literature, at a time when the new home on North Eutaw Street sorely needed professional assistance. Somehow, the spark of future genius was recognized in her eyes when she was interviewed by the search committee headed by Dr. William Osler.

Inheriting a small, unorganized, and outdated collection of about 7,000 medical books, this lady directed its metamorphosis into one of the better libraries on the East Coast. She was the entire staff for a prolonged period, but this intelligent, dedicated, full-time individual prescribed the proper therapy for the ailing, stumbling collection. Books were classified and coded, and donations were sought from the wealthier practitioner to fill the many holes in the collection. The inadequacy of the North Eutaw Street house

was soon apparent, and she prodded the doctors into a building campaign. The new structure was occupied in 1909 and provided a fine place for the growing library.

She became faculty secretary in 1904 and executive secretary in 1925. Besides caring for the library, she helped plan the annual meetings and dealt with the press and the politicians.

She retired in 1946 after having spent almost fifty years in devoted association with the Faculty. Few members will recall her, and the vast majority do not know her. The time has come to recognize and remember her in a way that she would have desired. Let the library she nurtured assume her name: the "Marcia C. Noyes Memorial Library." This small act of appreciation would repay only a meager portion of the debt that the Faculty owes to her.

JOSEPH M. MILLER, M.D.
Timonium ■



In light of this and of Miss Noyes' contributions to the growth and professionalization of the library, the Library and History Committee

Another alternative

Dr. Miller's letter is especially timely as the Faculty plans for its bicentennial in 1999. Marcia Noyes retired just three years short of the sesquicentennial, and in an interview outlined her goal for the Faculty—an endowment that would make Med Chi largely self-sufficient.

would like to modify slightly Dr. Miller's suggestion. Rather than naming the library after her, we plan to establish a Marcia Noyes Library Endowment Fund. Still in the planning stages, income from this endowment would be used for conservation, acquisitions, and staff. We feel this would be in keeping with the spirit of both Dr. Miller's suggestions and Miss Noyes' wishes.

Ronald H. Fishbein, M.D.
Chairperson, Library and History Committee
Chairperson, Ad Hoc Bicentennial Committee ■

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March						1993
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Editorial

U.C.R.

On the following pages, we have printed a summary of an interview between Victor Hrehorovich, M.D., editor of *MMJ*, and Mr. Frank Gunther, Jr., the newly appointed chairperson of Blue Cross and Blue Shield of Maryland (BCBSM). It is important to understand the context in which this exchange was held. ■ On July 2,

1992, Mr. John Donaho, the Maryland insurance commissioner, was summoned by Senator Sam Nunn (D-Ga.) to testify before the Senate Permanent Subcommittee on Investigations—the committee charged with probing abuse and fraud within the insurance industry.

As a consequence of Mr. Donaho's testimony, over 500,000 documents—representing 10 years of BCBSM fiscal data—were subpoenaed by the Senate committee. (You will find a summary of their conclusions beneath the Gunther interview.)

Most physicians believe that a nonprofit health insurance company must assure its subscribers that it will carefully shepherd and conserve premium health dollars. It is further widely held that investment in subsidiary for-profit ventures, particularly those removed from the field of medicine, is inappropriate and must be proscribed. This view extends equally to nonprofit hospitals, which often engage in comparable practices.

There is some skepticism regarding the ability of BCBSM to alter its business philosophy. After all, the deck may have been shuffled, but the cards remain the same.

One may well ask where the BCBSM board members stood when decisions were made to purchase Preakness tents, Camden Yard sky boxes, Olympic tickets, and golf club memberships.

Was there no protest when 1.8 million dollars was spent for executive moving expenses or 2.8 million dollars in foreign travel expenditures?

Where was the BCBSM board when Mr.

Sardegna's salary was raised from \$221,130 in 1986 to \$850,183 in 1991?

Were the board members troubled by the 21 percent rise in supplemental coverage for their Medicare recipients in 1990? And the additional 14.6 percent rise in 1991?

Did they not comprehend some relationship among those facts? And, assuming they did, why should we expect them to alter their principles now?

Finally, and somewhat tangentially, after reviewing the BCBSM story—is it really possible for anyone to believe that physicians are the cornerstone of rising medical costs?

Our patients often receive disturbing notices from BCBSM that warn that their doctor has billed more than the "U.C.R."

We should like to turn the table and charge the present board members of Blue Cross and Blue Shield of Maryland with correcting their own obvious imperfections. They can do so by exercising the kind of integrity that medicine has always evoked from physicians—

Usual, Customary, and Reasonable.

BARTON J. GERSHEN, M.D.

Note: Council will shortly be considering a resolution submitted by the Hospital Medical Staff Committee regarding misuse of patient care funds by nonprofit entities. ■

Frank A. Gunther, Jr., chairperson of the Board of Directors of Blue Cross and Blue Shield of Maryland—An interview with the editor

Betsy Newman

Ms. Newman is director of communications, Med Chi.

Following allegations of mismanagement by the US Senate Subcommittee on Permanent Investigations, Frank Gunther, Jr. replaced Carl Sardegna as chairperson of the Board of Directors of Blue Cross and Blue Shield of Maryland. Editor Victor R. Hrehorovich, M.D. questioned Mr. Gunther about the charges and his vision of BCBSM's future.

When Senate investigators released a scathing report about Blue Cross and Blue Shield of Maryland (BCBSM) in September, it left physicians and patients with many unanswered questions about the stability of the state's largest health insurer. Problems first surfaced in July when Maryland Insurance Commissioner John Donaho testified before the Senate Permanent Subcommittee on Investigations that the insurance commission had experienced difficulties in regulating BCBSM. The federal government's interest in the company began as early as October 1990 after West Virginia's Blue Cross and Blue Shield plan collapsed, leaving nearly 51,188 policyholders with \$42 million in unpaid medical bills. Concern over the bankruptcy and reports that several other Blue Cross-Blue Shield (BCBS) plans are experiencing financial or managerial problems, prompted the Senate subcommittee to look at fraud and abuse in the insurance industry. BCBSM was the first plan to undergo a Senate investigation. After analyzing ten years of financial data, and interviewing dozens of BCBSM officers, employees, accountants, auditors, and consultants, the subcommittee released its findings.

The subcommittee report

The executive summary of the report states "BCBSM has been beset by questionable management decisions, questionable financial practices, unprofitable subsidiaries which have been a drain on the plan's assets and resources to non-health insurance subsidiary activities, inadequate oversight by state regulators, questionable spending on matters not benefiting providers or subscribers, and a poor level of service to providers, subscribers, and the general public." The report goes on to note that BCBSM shows many of the same qualities of the now defunct West Virginia Blue Cross and Blue Shield plan and provides several specific criticisms. A summary of these findings begins at the bottom of the next page.

During the Senate subcommittee hearings, BCBSM defended many of its decisions and attempted to justify its expenses. For example, BCBSM claims that in order to compete with private insurers, its executive compensation package should be comparable with executive compensation packages offered by its competitors in the private sector. Keeping pace with private insurers was also how BCBSM executives rationalized many expenses such as the "Preakness Village" tents and Orioles sky box. Despite these explanations, there were many questions regarding BCBSM management and financial practices that were left unanswered.

In response to the subcommittee allegations and the unfavorable publicity, the BCBSM Board of Directors removed Carl Sardegna as their chairperson and replaced him with Frank A. Gunther, Jr. in October. Mr. Gunther, who has sat on the BCBSM Board of Directors for 10 years, is former owner of Albert Gunther, Inc., a Baltimore hardware business. Mr. Gunther has held positions on a number of hospital boards and is currently a member of the Maryland Board of Physician Quality Assurance. Mr. Gunther will head a Special Review

Committee that will address several of the Senate subcommittee's allegations and will focus on improving BCBSM's customer service.

As patient advocates, physicians have expressed concern about the quality of service provided to subscribers. Physician concern also extends to the cost-effectiveness of the plan and, ultimately, to the viability of the only nonprofit insurer in Maryland. For these reasons, *Maryland Medical Journal* Editor Victor R. Hrehorovich, M.D. met with Mr. Gunther on October 20, 1992 to talk about his plans for the future of BCBSM.

Dr. Hrehorovich: As members of the medical profession and patient advocates, physicians are concerned about the public's access to health care. BCBSM is the only nonprofit insurance company in the state. It has long played an important role in the provision of health care in Maryland. We would like to know what changes will be made to provide high quality services and to ensure the corporation's survival?

Mr. Gunther: My entire life has been built around community involvement, and I believe that a well-run BCBSM is important to the community. It would be an absolute disaster if, for any reason, it failed. That's why I took on this assignment, but I don't have all the answers.

I'm not really sure how we got to this point. I think there is a sense of embarrassment. Some of the material that appeared in the media certainly surprised the board, but I think we're a good board and we'll be a better one. There is a total commitment by the board to turn this situation around. No one on the board is going to walk away from this or resign. Whatever actions we take, will be actions of a unified board.

I plan to be very open with you this evening. If I don't feel I can

give you an answer because the board has not yet reached a consensus on an issue, I'll tell you.

H: The medical profession is being confronted with questions from our patients, who are concerned about what is going on. By raising questions this evening—to which you may or may not have the answers—I hope it will encourage your board to address the public's and the medical community's concerns.

In terms of the immediate challenges facing BCBSM based on the findings of the US Senate Subcommittee on Permanent Investigations, what solutions are being considered by your board?

G: Several things. Number one—we have to ensure that BCBSM continues to function and provide service. We can't focus all our attention and resources on answering questions. We have to concentrate on our primary mission.

Number two—the board must take the lead in rebuilding the public's confidence and trust in BCBSM.

Number three—we need to stop questioning whether BCBSM is going to fail. It's not a question as to whether BCBSM is financially sound or has a surplus—it does have a surplus. The question is: What is the size of the surplus? Although questions have been raised about the practices used to arrive at the bottom line, we have a surplus even if you remove all those questionable areas. I met with the insurance commissioner today and I hope that, by the end of the year, after all our subsidiaries have been evaluated by outside experts, we will be able to put forth solid, approved, financial statements on the part of our subsidiaries. I believe it will actually increase the surplus.

Number four—we have to restructure the operation of the board.

The findings of the US Senate Subcommittee on Permanent Investigations regarding Blue Cross and Blue Shield of Maryland (BCBSM) are summarized below based on the executive summary of the subcommittee's report.

Next to the allegations are actions taken by BCBSM as of press time.

Allegations

- "BCBSM has been beset by questionable management decisions, questionable financial practices, unprofitable subsidiaries that have been a drain on the plan's assets and resources, diversion of management and plan resources to non-health insurance subsidiary activities, inadequate oversight by state regulators, questionable spending on matters not benefiting providers or subscribers, and a poor level of service to providers, subscribers and the general public."¹

Questionable management decisions

- It is estimated that since 1986, BCBSM may have lost at least \$120 million on subsidiary ventures.²
- The company lost nearly \$30 million on risky for-profit subsidies that failed, such as Pertek, LifeCard, and Healthline.²

Questionable financial practices

- The Senate subcommittee contends that BCBSM's reported net worth may have been overstated by as much as \$100 million.³
- BCBSM misrepresented its true financial condition during a hearing in Annapolis in July by withholding a report by consultants Booz, Allen & Hamilton that questions the company's account of its reserves.³
- BCBSM blocked two government audits. The first in 1988, where it is thought that an audit may have shown BCBSM to be insolvent. The second in 1991, where executives used their political influence to conduct another independent audit rather than undergo an audit by the State Insurance Division.³

Excessive spending

- The company bought a \$300,000 sky box at Oriole Park at Camden Yards with catering bills that averaged \$588 dollars per game. In addition, BCBSM bought hundreds of season tickets between 1987 and 1991 costing between \$7,800 and \$10,000 annually.¹

Actions taken by BCBSM as of press time

- In early October, the board stripped company President Carl Sardegna of his title as board chairperson and set up a committee to examine ways to respond to Senate claims of poor management and financial health.⁴
- On November 16, BCBSM announced it will fold 11 inactive subsidiaries by December 1 and close down its arbitrage firm in a few months.⁶
- November 16, BCBSM acknowledged that \$88.1 million of the \$102.5 million it has listed in reserves for emergencies is there by special permission from state regulators rather than because it conforms to standard accounting rules.⁶

It's a talented, high-quality board that I believe has done a good job, but obviously we have to do a better job. It will probably have a much more elaborate committee structure, so that information will be fed to the board from other board members, as well as from management.

Over the long term, we have to look at some of the structures within BCBSM and the flow of information. It will be helpful if the board provides some immediate response to the general community. We have decided, however, not to answer questions in a piecemeal fashion. We want to deliberate in a timely, but thoughtful manner, and present answers in a total context. We want people to know that we are serious about getting BCBSM's ship in order.

H: Will the board be considering the cost/benefit ratio of the various marketing techniques used by the administration, such as the sky box at Oriole Park, the donations to the Baltimore Symphony, and the "Preakness Village" tents?

G: All the items questioned in the hearings, as well as those that have been raised by the news media, are being grouped into categories: financial concerns, personnel concerns, public relations concerns, etc. We are going to answer and respond to each of these concerns. There will be full disclosure so that no one can say "I didn't understand that" or "why didn't you tell us?" We intend to make BCBSM a totally open company.

H: The board includes many talented people, many of whom are experienced in business administration. When marketing strategies were put forth or when subsidiaries were proposed as a means to generate cash, was there a serious analysis of the cost/benefit ratio of these activities? How will such decisions be made in the future?

G: The board did not know about all of these things. We learned as the general public learned about them. We were aware of certain things, but didn't have all the specifics. It varied from item to item. I have to be honest with you, there are subsidiaries that the insurance commissioner did not approve, and the board was not aware of these.

I'm reluctant to tell you what we are going to do before the board votes on it, but we will be looking at every issue raised. We're going to look at the decision-making process. We will make it very clear as to what data the board will insist on having in the future and raise questions as to why we didn't have it in the past. We will be looking

at the marketing tools, the retirement programs, and executive compensation.

H: With regard to executive compensation, did I understand you correctly that the board was not fully aware of how the compensation was computed?

G: You asked me if the board was aware of all the items addressed by the House and Senate hearings. There was an Executive Compensation Committee of the board that discussed the details and reviewed the consultant's recommendations. The committee, in turn, would make a recommendation to the board. At that time, the board would not have all of the specifics and the data, but assumed that the Executive Compensation Committee had done a diligent job.

In terms of compensation, there will be an article in this Friday's *Sun* paper [October 23] dealing with Fred Gloth's retirement package. Mr. Gloth has long been BCBSM's general counsel, and is now serving as secretary and special assistant. He has been with BCBSM for 40 years. The board agreed on a process of how his package was to be derived (years of service, age, etc.). At that time, we did not have any actuarial figures showing what it cost in dollars and cents. When Mr. Gloth announced he would retire at the end of 1993, and the actual figures for retirement were calculated—reflecting current economic conditions and interest rates—the amount was quite substantial. The Executive Compensation Committee said, "This doesn't make any sense. Let's go back to the drawing board." There was no final agreement. It's being reconsidered by the Executive Compensation Committee and it's going to be re-examined by my Special Review Committee after they finish with it.

I'm not evading the question, but when people criticize what the board agreed to, they need to understand that the board agreed on a process, not a dollar amount.

H: There are objective criteria that can be used for determining compensation for CEOs, such as the fiscal performance of a company and the meeting of service goals. Do you plan to use such criteria to determine executive compensation?

G: We have a perception problem when you call BCBSM a nonprofit. It is, but we still pay federal taxes, and our competition is in the private sector. Seven of our top eight executives are from the

Allegations

- BCBSM sponsored two "Preakness Village" tents in 1992 at a cost of \$32,500.¹
- The company spent nearly \$9,000 last year at Baltimore's prestigious Center Club, plus an additional \$6,250 in initiation fees and \$1,250 annual membership fees for five top executives.¹
- BCBSM bought 64 vacation packages to the 1988 Winter Olympics totaling \$182,000 and four trips to the 1992 Summer Olympics for \$21,000. President Carl Sardegna canceled the 1992 trip because of the committee hearings.¹
- BCBSM paid for a corporate membership, costing \$75,000, at Cave's Valley Golf Course in Owings Mills, plus annual club dues of \$2,800 in 1991 and \$3,300 in 1992 for General Counsel Fred Gloth.¹

Charitable contributions

- BCBSM gave \$125,000 to the Baltimore Symphony (not to be acknowledged publicly). From 1988 through 1991, it donated \$53,000 to the National Aquarium, more than \$37,000 to Center Stage, more than \$18,000 to the Walters Art Gallery, and more than \$17,000 to the Baltimore Museum of Art.¹

Executive pay

- Mr. Sardegna's total compensation increased to \$850,193 in 1991 from \$221,130 in 1986, representing a 284 percent increase (including a base salary of \$406,000 and a \$300,000 bonus).¹

Actions taken

- October 22, 1992, the board voted to cancel the annual Preakness hospitality tents saying the event, formerly defended as a marketing tool to draw new business, had become a liability instead of an asset for the company.⁴
- The board voted October 22 to end its membership in the exclusive golf club.⁴

- Based on a decision by the board on October 22, bonuses will be tied to how well the company serves its 1.4 million subscribers, including the speed and accuracy of processing claims. It could eliminate bonuses for 1993 and perhaps longer.⁴

private sector. In looking at appropriate compensation packages, the question is: What universe should we use to arrive at our data? Over the years, the Executive Compensation Committee has hired various consultants from reputable firms. These consultants have used a much broader universe than just BCBS plans. In the private sector, companies base compensation on performance. Bonus arrangements and extra compensation are driven by the bottom line. Another perk in the private sector is stock options. That's not available at BCBSM. When we look at the level of compensation for our professional people, we're in roughly the 50th percentile compared with the entire executive compensation universe. When we compare our executive compensation packages with the major private insurance companies, we come out okay within that universe, too. But if we only look at the universe of BCBS plans across the nation, that's when we may be out of line.

I don't want to speak for the board, but I think we've learned from this. In the future, part of the compensation will be based on performance, but other criteria besides the bottom line will also be used, such as delivery of service. This is already done for some levels of employees (e.g., how quickly you answer the phones, how quickly you process paperwork). I think the board will recommend strict criteria for determining bonuses in the future and perhaps identify a different universe than was used in the past.

H: I'm glad you raised the question of quality of service. It's an issue of concern to patients and the medical community. Is the board going to address issues such as late payments, poor service, and lack of staff?

G: An incredible amount of money has been spent trying to develop a system to provide better services. I make no excuses for the less than perfect service. The board is aware of it and working to change it. You will see some substantial changes in the near future. But you should understand that the whole industry has changed. Fifteen to 20 years ago, you received a bill from the doctor and a bill from the hospital; you had two bills, you paid them. Today, people have the option of going to a hospital, an HMO [health maintenance organization], or a different provider. These options have created a nightmare in terms of paper flow and what the computer system can handle. We have seven, eight, or nine systems that are trying to manage this. We want to create a single information system to coordinate it all.

We haven't been able to do it yet, but we do have what we call the CARE system, which will reduce the number of systems handling the paperwork. We've implemented it in various segments of the corporation, and the early results look extremely encouraging. It is going to tremendously improve the time process.

One problem is that people call and complain that they sent a bill in on January 1, and it's now July 15, and they haven't been reimbursed yet. When we trace the problem, we find out that we didn't have all the necessary information. We can't complete the payment process until everything is received. We may have received one specialist's bill in January, but another component of the bill won't come in until February, then another comes in May.... All most people see is that the first bill was sent in January. No one disagrees that it has to be improved, and it will be.

H: Patients are more confused by the information they receive from BCBSM than information from any other insurance carrier. They receive statements that are not bills, and they don't understand them. What are your plans to address this?

G: That's part of customer service and we are making that a priority. In fact, executive compensation is tied to making that work, so I think you'll see some changes.

H: BCBSM is the administrator for Medicare, and yet claims have to be coded differently for Medicare than for BCBSM. The required paperwork is a nightmare. Some of my colleagues have suggested that BCBSM purposely bounces claims on technicalities so that it doesn't have to pay promptly. Do you have any comments?

G: There's a lot of validity to those frustrations. However, we find that sometimes you'll have a physician, hospital, or other provider say it takes 14 months to get paid, but when we track it down, we'll find out that 90% of the bill was paid in 30 days, and 10% took up to 14 months.

H: Assuming BCBSM is solvent, how will you expedite payments to physicians?

G: Expediting payments has nothing to do with solvency. It's a bookkeeping problem, not a financial problem. The resources are available to pay all outstanding claims.

H: Support/information services are severely lacking. It can take a physician an entire morning on the phone to address one problem. Do you have plans to address this issue?

Allegations

- The company's top 10 executives received a 181 percent increase in total compensation between 1986 and 1991, while all other employees received an average 28 percent increase during the same period.¹
- The number of employees making more than \$100,000 a year jumped from 10 in 1986 to more than 40 today, with nine making more than \$200,000 and five making more than \$300,000.¹
- General Counsel Fred Gloth's compensation jumped from \$98,987 in 1986 to \$572,596 in 1991, a 478 percent increase.¹
- BCBSM paid nearly \$18,000 a year in compensation to board members. (Members of the board were not paid prior to 1986.)¹

Administrative expenses

- The company spent \$1.8 million in moving expenses between 1986 and 1988 for 32 employees, including money to relocate a horse and two boats, as well as \$93,000 for Mr. Sardegna and his wife to move from Maine to Maryland. (That amount included a \$50,000 brokerage fee on the sale of his house.)¹
- BCBSM spent over \$2.8 million in travel expenses in 1991 alone, including overseas trips by executives to several countries in the Far East and trips to Amsterdam and Brussels.

Actions taken

- Days after Senate investigations subpoenaed salary and compensation records from Blue Cross in early July, the board agreed to change the generous nest egg for Fred Gloth.⁵
- On October 22, board members said they would cut their own pay to the average fees paid to boards of similar-sized BCBS plans.⁴

G: It's a service problem and again the same applies. We'll get everybody's attention when it is reflected in the paycheck.

H: A number of physicians believe BCBSM should provide prevention services. Do you have a plan to do that?

G: It's a legitimate question. Some procedures are being mandated, but understand that BCBSM cannot remain competitive if it has to provide more services than other insurance companies are required to provide. I think we already have an emphasis on prevention as well as managed care and related programs.

H: Getting back to the for-profit subsidiaries. Virginia regulators have barred BCBS of Virginia from creating any more for-profit ventures without special permission. What is the board's view of for-profit subsidiaries? Do you think they should be allowed?

G: I think they should be allowed if done for the right reason. The whole idea of establishing a for-profit subsidiary is to help the nonprofit core business offset some overhead costs. If establishing the venture is solely for the purpose of having a larger enterprise and trying to make money without any direct relationship to the core business, then I have a problem. I'd have a problem if a hospital opened up a for-profit used car lot, but I would not have a problem with a hospital opening up a for-profit parking garage to provide parking for hospital staff and patients.

H: Certainly one would not continue to create 29 or 30 subsidiaries, each one being a loss, and still hope that the 31st one would be profitable?

G: I agree with that. BCBSM will be looking at all its subsidiaries. It's better to do a few things well than a lot of things poorly. However, I don't want to eliminate the ability to create for-profit ventures to serve the parent company.

H: Over the past few years, BCBSM has entered into a number of business ventures that have done poorly. Mr. Sardegna reported that these have not resulted in premium increases. How is that possible? Who is paying for the losses?

G: Eighty percent of all the money lost was lost in the HMOs, not the ventures. We were providing care, but not collecting enough to pay for it. We're working to change the structure, reduce our overhead, and make the corporation more efficient. The 80 million dollars that

the media refers to was lost by the HMOs that provided more care than they could afford. This doesn't, however, excuse the fact that money was lost elsewhere.

H: BCBSM is affiliated with at least three HMOs. Are patient premiums being diverted to subsidize the HMOs?

G: No. At the current time, the latest data we have for the current fiscal year indicate that Columbia, Freestate, and Carefirst are all operating in the black.

H: Premiums have risen from \$3,000 to \$5,800 in three years. Is BCBSM pricing itself out of the market?

G: No. We have to stay competitive within the marketplace or we'd go out of business.

H: What can the state medical society do to help?

G: Be patient. Give the board time to respond. Remember that in spite of all the controversy, there have been no allegations of anything illegal, and no evidence of corruption, bribery, or pay-offs within the current organization. Some very legitimate questions have been raised about management style, but nothing illegal has occurred.

H: Weren't there some charges of embezzlement?

G: In those instances, the parent company, as soon as it became aware of it, took action and those people were dealt with. You cannot compare the current Maryland board and administration with what happened in West Virginia where there were collusion and sweetheart deals between the board and management. Nothing illegal transpired in Maryland.

H: What are your feelings about board compensation?

G: During my first 10 to 12 years on the board, there was no compensation. I didn't get involved in order to make money. When I first started on the Blue Shield board, there were about 25 people. Then we combined with the 25 people on the Blue Cross board. We ultimately decreased in size to 25, then to 15, and, finally, to 10. About six or seven years ago, with the advent of HMOs and other changes in the health care field, the work of the board became even more complex. I don't want, in any way, to demean the many talented people who had worked on the board for years, but a decision was made to try to get a more corporate viewpoint and to provide some compensation to the professionals on the board. Volunteers are sometimes not as devoted

Allegations

- The company sponsored marketing trips to Hilton Head, South Carolina that cost \$10,000 in ground transportation to shuttle employees to golf, shopping, tennis, and sailing, and \$46,000 in air fare for 200 people.¹
- In 1990, a round-trip limousine trip for Mr. Sardegna from Baltimore to Williamsburg cost \$800, and another to Washington and back to Baltimore cost \$532. This year, he spent \$418 for a chauffeured trip to Arlington, Virginia.¹
- Administrative expenses for the Maryland plan increased throughout the last decade to 12.3 percent in 1990.¹

Poor customer service

- Productivity at BCBSM is estimated to have dropped by 4 or 5 percent due to high administrative costs according to a report by Booz, Allen & Hamilton.³
- The subcommittee report criticized BCBSM for being "at best conservative, and at worst brutal in its decisions denying benefits to subscribers."³
- In comparison with other Blue's plans, BCBSM has been near the bottom of the list for claims processing and client service since 1988.³

Impact on consumers

- Premiums have risen from \$3,000 a year in 1988 to \$5,800 a year for the group conversion plan, the most popular Blue Cross-Blue Shield plan covering individuals.¹

Actions taken

as those who are being paid for a task. I hope I don't make anyone angry by saying that, I'm just trying to be honest with you.

We have learned that our compensation is out of line with the national BCBS plans but not the general corporate universe. We're currently gathering data on an even smaller universe—competitors and other BCBS corporations of similar size. If the results suggest we should get no compensation, then that's how it will be.

H: Do you see any conflict of interest between your position on the Board of Physician Quality Assurance (BPQA) and your new position on the BCBSM board?

G: I don't know why there would be a conflict. If someone believes it is a conflict, I'd be willing to listen to their concerns. I'd have no problem resigning from the BPQA.

H: BCBSM started as a physician concept, but now there are only two physicians on the board. Do you plan to increase physician input and representation?

G: When we initially reduced the size of the board, we tried to keep physician representation at 25%. But with retirements and other factors, we're not at that level. The change was not a conscious decision. It's a valid recommendation and will be taken under consideration by the board.

H: In view of the huge executive salaries and the luxurious and arrogant perks, physicians ask how BCBSM can turn to them and say they are charging too much.

G: There are a couple of answers to that. We are nonprofit, but we're competing in the private arena. Our competition (e.g., Cigna) in the private sector provides these types of perks. I'm not saying that in hindsight, in some instances, we went too far. Those things will get far more scrutiny in the future than they received in the past.

If you were to put all the perks into one package and compare it with what percent of the total operating budget they represent, you would find they would have a negligible effect on premium costs. A couple of million dollars in a two billion dollar budget is a small amount. I'm not suggesting that it's right, but we need to put it into context. I hope that if the board takes definite action and curtails or eliminates all the perks, the public doesn't expect to see an incredible difference in the premiums being paid.

H: Of course to paraphrase Everett Dirksen, "a million here, a million there, and pretty soon we're talking about real money."

How do you justify moving to a new, expensive facility in Owings Mills and selling a building with structural flaws to the county?

G: We became aware that the Towson building had asbestos. Estimates for removal were eight to ten million dollars. We didn't want to spend that money, disrupt services, and move people out and back in. We also had people in other locations besides the main Towson building. It made sense to consolidate operations. After studying the issue, a proposal was presented to the board to erect a building in Owings Mills. The proposal compared the cost of operating the Towson building and removing the asbestos with the cost of moving to Owings Mills. Over a 20-year cycle, it was projected that we would save 22 million dollars in overhead by going to Owings Mills, so the decision was made to move. A number of unforeseen things happened, as often do when you make a change of this magnitude, so a re-review of the data was conducted after the move was completed. It turns out that it was not as good a deal as originally forecast, but we still saved money for subscribers. To the best of my knowledge and the best information I have, the move was a positive one for subscribers and employees.

H: What do you see in the future for the board?

G: I see the board's plan as short-term responses to the questions raised in the media, but with an emphasis on continuing to run efficient day-to-day operations. We have to rethink, redesign, and restructure the way the board operates. We have to do some long-term planning to prevent problems like this from happening in the future. And we have to do all of this under the tight schedules of very busy people who serve on this board part-time.

H: Is there any possibility of management changes?

G: I think that's a reasonable possibility. I think it's also reasonable to assume that the board might need some outside consultants. We are going to do whatever has to be done in order to regain public confidence and make BCBSM a well-run corporation.

H: When the board has made some decisions, will you come back and talk with us again?

G: Yes, I will be happy to meet with you anytime to share what we have done and where we are going. ■

Allegations

- A basic BCBSM policy to supplement what Medicare covers for people over 65 increased 21 percent in 1990 and 14.8 percent in 1991.¹
- A new computer system to help overcome "serious shortcomings" in the company's claims processing system has already cost between \$20 million and \$26 million, compared with the \$9 million originally estimated. The system will cost an additional \$20 million to \$30 million to become fully functional in the mid-90s.¹

1. U.S. Senate Study of MD. Blues. *Baltimore Sun*. September 25, 1992; 2-3.
2. Blues ventures often went awry. *Baltimore Sun*. October 4, 1992.
3. Senate probe finds deep flaws in MD Blues. *Baltimore Sun*. September 25, 1992.
4. Blues board agrees to cancel bonuses for top executives, sell Orioles sky box. *Baltimore Sun*. October 23, 1992; 14A.
5. Blues official got \$3.6 million retirement plan. *Baltimore Sun*. October 23, 1992; 1A & 14A.
6. Blues post gain for quarter. *Baltimore Sun* November 17, 1992; 12C & 19C.

Actions taken

Physician estimates of substance abuse in Baltimore and Cumberland: 1991

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By identifying and counseling substance abusers within their own practices, primary care physicians can play a major role in reducing levels of substance abuse. How proficient area physicians are in identifying substance abuse is examined by comparing physician estimates of substance abuse in their patient populations with local and national statistics.

From the Medical and Chirurgical Faculty of Maryland where Dr. Valente is deputy executive director, Mr. Troisi is executive director and Ms. Duszynski is project coordinator; The Johns Hopkins University School of Medicine where Dr. Smoot is assistant dean of Student Affairs and Dr. Levine is professor of medicine and director, Division of Internal Medicine; and the University of Maryland School of Medicine where Dr. Ferentz is assistant professor of family medicine.

In an effort to reduce the rate of substance abuse in the United States, the Center For Substance Abuse Treatment of the Alcohol, Drug Abuse, and Mental Health Administration has launched a campaign to recruit primary care physicians in the war on drugs.¹ These physicians see a wide cross section of the general population on a regular basis and are in a unique position to make an early identification of patients who are substance abusers.² Because they are considered by patients to be the best and most reliable source of health information, physicians can also wield considerable influence in helping patients seek treatment for substance abuse.³⁻⁵

A major portion of the effort to involve physicians in substance abuse treatment is being channeled through the Center For Substance Abuse Treatment's Target Cities Program. Fifty cities nationwide were invited to compete for funds to improve their substance abuse treatment systems. Of the 11 cities whose applications were approved, Baltimore City received the highest priority, and was one of only eight cities actually funded. As administered by Baltimore Substance Abuse Systems, Inc. (BSAS), a major component of the project is integration of primary care and substance abuse treatment. This objective is being accomplished by providing primary medical care in substance abuse treatment programs; by providing substance abuse services in primary health care settings; and by training primary care physicians in the identification, treatment, and referral of substance abusers. In order to fulfill the last of these goals, BSAS contracted with the Monumental City Medical Society and with the Medical and Chirurgical Faculty of Maryland (Med Chi) to provide substance abuse education for primary care physicians in Baltimore City.

Med Chi's first step was a two-pronged needs assessment consisting of a mailed questionnaire and focus group discussions. The questionnaire,

designed as a quantitative measure of physicians' attitudes, knowledge, and practice patterns regarding substance abuse, was mailed first. After the questionnaire results were tallied and a number of talking points were identified, a series of focus group discussions on qualitative issues were carried out. Med Chi then developed the first of several substance abuse education modules designed to meet the specific needs of area physicians; the curriculum is currently being offered at various sites in Baltimore City. The results presented here focus on physician estimates of patient substance abuse as reported on the mailed questionnaire; these estimates are then discussed in light of local and national statistics.

Methods

The questionnaire was mailed to physicians practicing in both the Baltimore metropolitan and Cumberland areas; Cumberland physicians provided a rural perspective on substance usage. US Postal Service definitions of the two areas were used, so that the Cumberland area comprised all of Garrett and most of Allegany counties, and the Baltimore metropolitan area included all of Baltimore City, Baltimore County, Harford County, and parts of Carroll, Howard, and Anne Arundel counties. The primary care specialties surveyed included family and general practice, internal medicine, pediatrics, and obstetrics/gynecology. Although physicians specializing in general surgery, psychiatry, and neurology were also surveyed, they are not considered in the present report. Names and addresses of physicians were drawn from the American Medical Association (AMA) Master File. A 50 percent random sample was selected from each of the specialties, except general practice, in the Baltimore metropolitan area. All general practitioners and all physicians in the Cumberland area were surveyed in order to ensure adequate sample size.

On the questionnaire, physicians were asked whether or not they encountered patients in their day-to-day practice who abused alcohol or drugs. Those who did encounter substance abuse were then asked if they had encountered any patients in the past year who had abused the following substances: alcohol, opiates, cocaine, amphetamines or methamphetamines, tranquilizers, barbiturates, inhalants, marijuana/hashish, hallucinogens, or phencyclidine hydrochloride (PCP). They were also asked to estimate what proportion of their patient population in the past year habitually abused alcohol; abused any prescription drug; and/or abused any illicit drug.

The first mailing of the questionnaire was sent in November 1991, with two subsequent mailings at monthly intervals. A unique identification number was assigned to each physician and

printed on his/her questionnaire in order to avoid repeat mailings to those who had already responded. The key to the identification number was only available to one staff member.

Results

A total of 1,249 primary care physicians in the Baltimore metropolitan area and 62 in the Cumberland area were surveyed. Sixty percent, or 793 physicians, returned a questionnaire. Return rates by specialty were as follows: family practice, 63 percent; general practice, 58 percent; internal medicine, 58 percent; obstetrics/gynecology, 61 percent; and pediatrics, 63 percent. Characteristics of the total respondents as compared with the total sample are presented in Table 1. There were no significant differences between respondents and nonrespondents by area surveyed, specialty interest, or age, although somewhat fewer women than men returned questionnaires (chi-square = 5.48, 1 d.f., $p = .02$).

Average age of the respondents was 47.8 years. The largest proportion of respondents was in solo practice (40 percent), while 29 percent were in group practice, 11 percent were in hospital-based practice, and 20 percent practiced in other settings, such as health maintenance organizations (HMOs), community health centers, or the military. These physicians saw a mean of 82.5 patients per week. In regard to their patient populations, an average of 18 percent received medical assistance and 29 percent were nonwhite.

Overall, 603, or 76 percent of the 793 respondents, reported that they encountered substance abusers in their practice. Nearly all of the physicians who encountered substance abuse reported seeing patients who abused alcohol (96 percent). Of other drugs, 67 percent of the physicians indicated they encountered opiate abuse; 66 percent, cocaine abuse; 64 percent, tranquilizer abuse; and 56 percent, abuse of marijuana. The average number of substances encountered was

Table 1. Characteristics of all respondents compared with total sample

	Total sample		Total respondents	
Specialty	N	%	N	%
Family practice	186	14	118	15
General practice	130	10	76	9
Internal medicine	421	32	243	31
Obstetrics/gynecology	275	21	167	21
Pediatrics	<u>299</u>	<u>23</u>	<u>189</u>	<u>24</u>
Total	1,311	100	793	100
Area				
Baltimore	1,249	95	749	94
Cumberland	<u>62</u>	<u>5</u>	<u>44</u>	<u>6</u>
Total	1,311	100	793	100
Sex				
Male	994	76	619	78
Female	<u>317</u>	<u>24</u>	<u>174</u>	<u>22</u>
Total	1,311	100	793	100

4.3. These physicians estimated that 6.3 percent of their patient populations habitually abused alcohol, 3.4 percent abused prescription drugs, and 4 percent abused illegal drugs.

Geographic area. The distribution of physicians in the Baltimore and Cumberland areas was significantly different by both specialty (chi-square = 14.26, 4 d.f., $p < .01$) and type of practice (chi-square = 12.37, 6 d.f., $p = .05$). More physicians in the Cumberland area than in the Baltimore area were in family practice (34 percent vs 14 percent), and a larger proportion were in solo practice (62 percent vs 39 percent). Physicians in Cumberland reported seeing a significantly greater number of patients per week than Baltimore physicians (101.1 vs 81.5, $t = 2.78$, $p < .01$), and a significantly lower proportion of nonwhite patients (4 percent vs 31 percent, $t = 5.94$, $p < .001$). Although Cumberland physicians also saw a higher percentage of patients receiving medical assistance (25 percent vs 17 percent), the difference was not significant ($t = 1.78$, $p = .08$).

There was no difference between the Baltimore metropolitan and Cumberland areas in the proportion of primary care physicians encountering substance abusers. However, a few significant differences were found between the two geographical areas in the proportion of physicians encountering specific types of substance abuse (Table 2). More physicians in the Baltimore metropolitan area indicated that they encountered patients who abused cocaine or marijuana. There were no significant differences between the areas, however, in the proportion of physicians who reported seeing patients who abused alcohol, opiates, amphetamines, tranquilizers, barbiturates, inhalants, hallucinogens, or PCP, or in the number of different substances encountered.

Baltimore physicians were more likely to have seen patients who tested positive for the human immunodeficiency virus (HIV). And, when the various substances of abuse were grouped, a larger proportion of Baltimore physicians encountered patients who abused illicit drugs. No significant differences were found, however, in the proportions of physicians encountering patients who abused prescription or intravenous drugs. Patient populations in the two areas were also compared, and no significant differences were found between proportions of patients abusing any group of drugs.

Specialty. There were a number of significant differences in the general characteristics of the patient populations of the various primary care specialties (Table 3). Family practitioners and pediatricians reported seeing a greater average number of patients per week than did obstetricians/gynecologists or internists. Compared with other specialties, pediatricians also saw the highest proportions of nonwhite patients and patients receiving medical assistance.

In regard to the proportion of physicians encountering substance abusers, family physicians (90 percent), general practitioners (87 percent), and internists (91 percent) were much more likely to indicate that they encountered substance abusers than were obstetricians/gynecologists (65 percent) or pediatricians (53 percent) (chi-square = 112.13, 4 d.f., $p < .001$). Similarly, of those physicians who indicated they encountered substance abusers, family and general practitioners and internists encountered a greater average number of different substances than did obstetricians/gynecologists or pediatricians ($F = 13.08$; 4,578 d.f.; $p < .001$). The mean number of substances encountered was 4.7 for internists, 4.8 for family physicians, and 4.5 for general practitioners. Pediatricians saw an average of 3.3 different substances, obstetricians/gynecologists, 3.5.

Table 4 illustrates the differences between specialties in regard to specific types of substance abuse. Significantly larger proportions of internists and family and general practitioners encountered abuse of alcohol, opiates, tranquilizers, barbiturates, and prescription drugs as compared with pediatricians or obstetricians/gynecologists. Family practitioners and internists were also most likely to see patients who abused intravenous drugs or who tested positive for HIV. On the

Table 2. Proportion of physicians by geographical area encountering specific types of substance abuse

	Baltimore	Cumberland	Chi-square	p
Alcohol	95%	100%	1.67	NS
Opiates	67	60	0.84	NS
Cocaine	68	37	14.06	<.001
Amphetamines	18	14	0.35	NS
Tranquilizers	63	69	0.37	NS
Barbiturates	21	29	1.12	NS
Inhalants	8	11	0.50	NS
Marijuana	57	40	4.09	= .04
Hallucinogens	12	11	0.01	NS
PCP	16	9	1.40	NS
Any prescription abuse	79	77	0.05	NS
Any abuse of illicit drugs	80	61	7.14	<.01
Any intravenous abuse	53	39	2.88	NS
Positive for HIV	56	33	7.02	<.01

other hand, pediatricians were the most likely to encounter hallucinogens, and obstetricians/gynecologists, along with family practitioners and internists, were the most likely to encounter abuse of illicit drugs.

Proportions of the patient population abusing alcohol, prescription drugs, and illicit drugs as reported by specialty are shown in Table 5. Internists and family and general practitioners saw significantly higher proportions of patients abusing alcohol and prescription drugs than did pediatricians and obstetricians/gynecologists. There was no difference

among specialties in the proportions of the patient population abusing illicit drugs.

Discussion

Several recent studies demonstrate the wisdom behind the effort to involve primary care physicians in substance abuse treatment. In each of these studies, a physician's simple warning to alcohol-abusing patients to cut down on drinking produced measurable and significant reductions in patients' alcohol consumption from one to four years later.⁶⁻⁸ In

order to issue such warnings, however, physicians must first be able to identify which of their patients are substance abusers, and a number of studies have shown that physicians are not generally successful in doing so.⁸⁻¹² How successful area physicians are in identifying substance abuse can be measured, *to some extent*, by comparing the substance abuse rates reported here with national and local statistics.

In the present study, 55 percent of physicians who admitted encountering substance abuse reported that they had seen at least one patient in the past year who had tested positive for HIV. This figure is consistent with the findings of Bresolin et

Table 3. Patient population characteristics by specialty

	Patients per week (mean)	% nonwhite patients (mean)	% medical assistance (mean)
Family practice	99.17	20.84	13.58
General practice	81.70	30.91	21.67
Internal medicine	73.03	29.43	14.96
Pediatrics	92.54	35.20	27.75
Obstetrics/gynecology	74.86	27.30	12.18
F	11.01	4.86	12.38
d.f.	4,721	4,756	4,751
p	<.001	<.001	<.001

Table 4. Proportion of physicians encountering specific types of substance abuse by specialty

	Family practice	General practice	Internal medicine	Pediatrics	Ob/ Gyn	Chi-square	p
Alcohol	99%	95%	99%	88%	93%	22.12	<.001
Opiates	78	75	76	42	54	49.98	<.001
Cocaine	70	65	68	59	66	3.09	NS
Amphetamines	20	20	21	10	15	7.16	NS
Tranquilizers	81	86	78	13	47	163.74	<.001
Barbiturates	28	23	30	4	11	34.58	<.001
Inhalants	12	12	8	10	1	10.95	= .03
Marijuana	60	49	56	63	51	5.11	NS
Hallucinogens	12	11	12	20	4	12.44	= .01
PCP	22	11	17	16	9	7.75	NS
Any prescription abuse	93	89	89	34	76	138.15	<.001
Any abuse of illicit drugs	84	59	81	73	83	17.23	<.01
Any intravenous abuse	64	49	61	28	45	35.10	<.001
Positive for HIV	63	49	68	36	37	45.25	<.001

al,¹³ who reported that while 38 percent of US physicians had treated a patient with acquired immunodeficiency syndrome (AIDS), significantly more physicians in the middle Atlantic region had done so. Other indications of substance abuse in this survey sample, however, are low compared with national statistics. Physicians in this study estimated that an average 3.4 percent of their patient population had abused a prescription drug in the year prior to the survey compared with the national estimate of 4.3 percent; only 4 percent of patients were estimated to have abused an illicit drug compared with 13.3 percent nationally; and 6.3 percent of patients were estimated to have had problems with alcohol as compared with a 10 percent national estimate.^{2,14}

What may be most troubling in the current study, however, is the number of physicians who reported that they did not encounter substance abuse of any kind. Of the 190 physicians (24 percent of the total respondents) who denied encountering substance abuse, 47 percent were pediatricians and 31 percent were obstetricians/gynecologists. Some reduction in the proportion of pediatricians seeing substance abusers might be expected, since a number of pediatricians do not see adolescent patients, and since children, in general, have lower rates of substance abuse than their elders. While children's rates are lower, however, they are not negligible. Findings from the 1990 Maryland Adolescent Survey, for example, showed that nearly one-third of twelfth graders in Maryland engaged in binge drinking on at least one occasion in the month prior to the survey.¹⁵ Nationally, 14 percent of all 12–17 year olds reported that they had tried to cut down on their alcohol consumption in the past year and over two percent drank every day.¹⁶ In regard to other drugs, Maryland's high school seniors were above 1990 national estimates in their use of inhalants, crack, steroids, amphetamines, methamphetamines, heroin, other narcotics, PCP, and lysergic acid diethylamide (LSD).¹⁵

Nor is substance abuse among youth limited to older adolescents. Seven percent of Maryland sixth graders reported drug use in the month prior to the 1990 Maryland Adolescent Survey and more sixth graders reported using inhalants than tobacco.¹⁵ Looking at age at initiation into

substance abuse retrospectively, 16 percent of all those admitted to treatment programs in Maryland in 1991 indicated that they began to use alcohol in elementary school.¹⁵ Additionally, 43 percent of inhalant abuse, 23 percent of marijuana abuse, and 17 percent of hallucinogen abuse began prior to age 14.

Like pediatricians, obstetricians/gynecologists might also be expected to see fewer substance abusers, since women generally have lower rates of substance abuse than men. Although their rates are lower, the number of women affected by substance abuse is large. Nationally, it is estimated that 4.6 million women are problem drinkers, accounting for nearly a third of all alcohol abuse.¹⁷ And, 11.4 percent of the total female population aged 12 or over is estimated to have used an illicit drug in the past year.¹⁴ Perhaps more significantly, 15 percent of all women of childbearing age are estimated to be current substance abusers, with as many as 375,000 infants a year affected by their mother's drug use.¹⁸ Given these numbers, it is difficult to see how 35 percent of the obstetricians/gynecologists surveyed and 47 percent of the pediatricians failed to encounter *any* substance-abusing patients in their practices.

Although major differences in substance abuse rates might have been expected by area, a greater number of differences were found among the specialties surveyed than between geographical areas. While a few differences between Baltimore and Cumberland were found with regard to specific drugs, similar proportions of physicians in both areas encountered substance abuse. It seems that, while areas may differ in the kinds of substances abused, there is no area that is free of substance abuse.

The problem of substance abuse is a pervasive one. Although substance abusers are generally overrepresented in primary care patient populations,¹¹ Maryland physicians' estimates of substance abuse are lower than national estimates. A number of short, easily administered screening tools have been developed specifically for use by physicians. These include the CAGE (four questions), T-ACE (four questions), Skinner Trauma Scale (five questions), BMAST (10 questions), and SMAST (13 questions).^{19–23} Each of these tools

Table 5. Mean proportion of patient population abusing substances by specialty

	Alcohol	Prescription drugs	Illicit drugs
Family practice	8.07	3.78	4.42
General practice	6.31	4.83	3.18
Internal medicine	8.75	4.77	4.65
Pediatrics	2.39	0.41	3.18
Obstetrics/gynecology	2.50	2.18	3.59
F	16.64	14.50	1.16
d.f.	4,560	4,553	4,545
p	<.001	<.001	NS

has been shown to improve physicians' recognition of substance abuse.²⁴⁻²⁶ Considering what powerful agents for change physicians can be, routine incorporation of these screening devices in primary care practices would represent an important first step toward reducing levels of substance abuse in Maryland.

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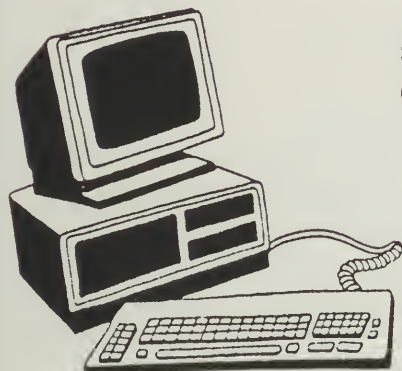
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Functional improvement in geriatric trauma patients admitted to a dedicated rehabilitation hospital

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Drs. Radke and Smith were preventive medicine residents when this study was conducted. Dr. Flynn is director of Corporate Rehabilitation Services at the University of Maryland Medical System. Dr. Scott is research associate and Dr. Permutt is assistant professor in the Department of Epidemiology and Preventive Medicine at the University of Maryland School of Medicine. Reprints: James P.G. Flynn, M.D., UMMS, 22 S. Greene St., Baltimore, MD 21201-1595.

A retrospective study was undertaken of trauma patients over 55 years of age who were admitted to a rehabilitation hospital during an 18-month period. Significant risk factors for poorer in-hospital improvement in functional independent measures were male sex, having an offspring listed as next of kin, pre-injury diabetes mellitus and/or dementia, and number of comorbidities. Being married was found to be protective.

In the United States, 28.5 million people (11 percent of the population) are older than 65 years of age. By the year 2020, it is expected that 51 million individuals will be in this age group.¹ As a result of these demographic changes, the number of individuals at risk for mortality and morbidity due to injury will rise, and the costs of care for the elderly will increase greatly.²

Trauma causes hospitalization of approximately two million Americans each year. Trauma patients occupy one-eighth of all hospital beds and account for \$237 million per day (\$87.4 billion per year) in direct medical costs and lost productivity.³

The elderly suffer disproportionately from trauma; relatively minor injuries often lead to hospitalization, and older patients are more likely to die of their injuries.^{2,4} Because injury in the elderly results in relatively high morbidity and mortality, this segment of the population consumes nearly one-third of the health care resources expended in trauma care.²

Trauma is the fourth leading cause of death in people over age 55, and the fifth leading cause of death in those over age 65. Approximately 30,000 deaths per year are attributable to trauma in those aged 65 years and older.^{2,4,5} Furthermore, trauma is probably underreported and, therefore, is a more prevalent cause of death in the elderly than officially recognized.²

The most common causes of injury in the elderly are falls, motor vehicle crashes (driver or passenger), pedestrian/motor vehicle crashes, assaults, burns, and incidents involving machinery and tools.^{2,4-8} Elderly women have higher rates of injury from falls than elderly men, who have higher injury rates from burns and motor vehicle crashes (including pedestrian injuries).⁹ Men have higher death rates from each of these

three categories of injury; nonwhite men have the higher injury death rates up to age 74, but by age 75, white men have the higher rates.⁹ Among persons aged 65 to 74, more than one-third of deaths from injury are due to motor vehicle crashes and nearly one-fourth are due to falls.⁹ By age 75, half the deaths from injury are attributed to falls, and less than one-fifth result from motor vehicle crashes.⁹ The most common types of injury among the elderly are hip fractures, head trauma, spinal cord injury, and thermal injuries.^{2,4,5,6,9,10}

The Abbreviated Injury Scale (AIS) is the most widely used anatomic scale in epidemiologic studies requiring the rating of injury severity. The AIS is a numeric scale ranging from 1 (minor injury) to 6 (maximum injury—unsurvivable) and is used to rank the severity of individual injuries grouped by body region. The six body regions are (1) head and neck, (2) face, (3) chest, (4) abdominal or pelvic contents, (5) extremities or pelvic girdle, and (6) external.^{11,12} The Injury Severity Score (ISS), used to assess the combined effect of multiple injuries on any given person, is defined as the sum of the squares of the highest AIS score in each of the three most severely injured body regions; however, if an injury of AIS 6 severity is sustained, then the ISS score automatically becomes 75, the maximum ISS possible.

The AIS has been found to be predictive of injury-related mortality, and the ISS has been shown to correlate well with mortality and length of hospital stay. The AIS/ISS, however, has a nonlinear relationship with disability and is not a good predictor of functional disability at hospital discharge or six months later.¹³

Most of what is known about the extent of disability after trauma comes from studies of the young adult and middle-aged populations. The relationship between injury severity and functional disability was investigated among trauma patients without severe brain injury by MacKenzie and colleagues.¹⁴ They found that for 479 survivors of trauma center admissions aged 16 to 45 years who were followed for one year, 57 percent had no physical restrictions and 16 percent had only minor limitations that did not interfere with mobility or self-care. Also, 57 percent of those working full-time prior to their injuries returned to full-time employment within one year.

The results of six studies of the conditions and dispositions of elderly trauma patients are summarized in **Table 1**.

The goal of medical rehabilitation is to decrease disability in physically impaired individuals. One scale used to assess disability is the Functional Independence Measure (FIM).¹⁵ In this scale, disability is characterized by level of independent function in the life activities of self-care, sphincter control, mobility, locomotion, communication, and social cognition. The FIM is designed to measure level of disability in all age groups and in multiple settings, regardless of the clinical training of the assessor and the nature or extent of the impairment. The FIM has been used since 1985 with good validity and reliability.¹⁵

The basis of the FIM is the burden of care (type and amount of assistance) needed for a disabled individual to perform

basic life activities effectively. This reflects the cost of disability in social and economic terms.

There is little information in the medical literature about the circumstances and outcomes of those patients who present to dedicated rehabilitation hospitals. Those referred represent a middle subset of all elderly trauma victims, in that those with the worst outcomes, including nonsurvivors and those thought incapable of functional improvement, are not referred for rehabilitation, nor are those with the best results—those with either no or minimal residual disabilities. The extent to which patients referred for rehabilitation improve, patient characteristics associated with the degree of improvement, and final disposition of the patient were examined in this study.

Methods

The study group consisted of injured patients 55 years of age or older consecutively admitted to a rehabilitation hospital during the 18-month period from January 1, 1988, through June 30, 1989. Patients are evaluated for admission on the basis of their ability to participate in a comprehensive rehabilitation program with an emphasis on discharge possibilities.

Computer-generated census lists indicating patient name, a numeric identifier, admission date, age, and diagnoses were examined. The charts of those appearing to meet study criteria were examined, and those meeting entry criteria were abstracted by one of three resident physicians.

ISSs were assigned by abstracting the records of the immediate post-injury hospitalization and/or the rehabilitation hospital admission notes. AIS scores (an intermediate step in the generation of the ISSs) were assigned for all recorded diagnoses using the 1985 Abbreviated Injury Scale.

Individuals who developed medical complications necessitating their transfer from the rehabilitation hospital to an acute-care hospital were excluded from analysis if they did not return to the rehabilitation facility.

FIMs were abstracted directly from the hospital FIM form. Missing values were encountered in a significant proportion of these forms, necessitating the following data manipulations: Where both admission and discharge scores for a given activity were missing, the value of 4 (the maximum possible score) was assigned to both. We believe that this had a neutral effect on the "change in FIM" score. Where either the admission or discharge score for a particular activity was missing, the missing value was set as equal to its recorded counterpart. For instance, if the admission score indicating "ability to dress the upper body" was missing, but the discharge score for this same activity was recorded as 3, then the admission score was also set at 3.

The functional scales of six patients who had sustained spinal trauma were found to be based on a scale of 7, instead of the more prevalent use of a 4-as-maximum scale. These six records were converted to the 4-based scale, as there was exact correspondence between functional descriptors of the two scales.

Table 1. Comparison of studies of elderly patients

Investigators	Population	Mean ISS	Results	Comments
Broos, 1988	38 survivors of polytrauma, mean age 72.1 yr, formerly independent	32.2	76.6% were living at home 6 months after injury	Netherlands
Oreskovich, 1984	100 multitrauma victims, >70 yr, admitted to trauma center		86 survivors; one year post injury—8% were functionally independent, 72% were receiving full nursing care, 20% required home assistance	Predominantly female population
Allen & Schwab, 1985	48 patients with blunt chest trauma, >60 yr of age. Mean age 72, admitted to one of three major trauma referral centers.	18 (range 5–41)	90% discharged to home; of these, 9% required partial assistance; 8% required long-term nursing care; 2% died in-hospital	
DeGeutis et al, 1985	>65 yr and injured, not necessarily multiply-injured, in general hospitals. Mean age 78.4 yr	7.8	34% returned to previous level of functioning by time of discharge. 47% with minimal, 15% with moderate to severe disability. For hip fracture patients, 27.4% back to baseline at discharge, 21% with moderate to severe disability	43% of population had hip fracture
DeMaria, 1987	63 survivors of blunt trauma at a trauma service; 62% had polytrauma	15.8	9–38 month follow-up (mean 19.6 months); 19 discharged to nursing homes, 12 later discharged to home; 23 (36.5%) discharged to community as dependent; 13 of these 23 later became independent	
Smith DP, 1990	456, admitted to hospital trauma center with any injury; mean age 76.1 yr	10.8	8.6% mortality; 58% female premorbidities not associated with survival	

Simple descriptive analyses, univariate analyses, and multiple logistic regressions were performed using the SAS computer program.

Results

Sixty-five individuals met the study criteria. Two who met inclusion criteria developed acute medical problems necessitating transfer to another facility, and, as neither returned to the rehabilitation center, both were excluded.

The results of the descriptive analyses are found in

Tables 2A and 2B, where separate analyses are provided for the combined population and the age groups 55 to 64 and 65 years and over.

The two age groups differed substantially. The 55- to 64-year-old group was largely nonwhite and male, with more referrals from trauma centers. Motor vehicle collisions were the dominant mechanism of injury (**Figure 1**), and this group had a fairly high proportion of head and spine injuries (**Figure 2**) and relatively higher ISSs than the older group (**Figure 3**).

The 65-year-and-older group was largely female and

Table 2A. Patient characteristics and descriptors				Table 2B. Patient characteristics and descriptors			
Variable	Total (%)	55-64 yrs. old (%)	65 yrs. plus (%)	Variable	Total (%)	55-64 yrs. old (%)	65 yrs. plus (%)
Number	63	31	32	Injury Severity Score			
Age				1-5	9 (14.5)	2 (6.7)	7 (21.9)
White	67.7 (SD 8.56)	60.3 (SD 2.49)	74.96 (SD 5.54)	6-10	29 (46.8)	9 (30.0)	20 (62.5)
Male	37 (58.7)	15 (48.5)	22 (68.7)	11-17	12 (19.4)	9 (30.0)	3 (9.4)
% of whites	30 (47.6)	21 (67.7)	9 (28.1)	18-26	9 (14.5)	7 (23.3)	2 (6.2)
% of nonwhites	(37.8)	(53.3)	(27.27)	≥27	3 (4.8)	3 (10.0)	0
Occupation	(61.5)	(81.25)	(30.0)	Diabetes mellitus	9 (14.1)	5 (15.6)	4 (12.5)
Employed	15 (23.8)	12 (38)	3 (9.4)	Cognitive impairment	10 (15.6)	6 (18.8)	4 (12.5)
Retired	31 (49.2)	5 (16.1)	26 (81.3)	Comorbidities			
Unemployed	14 (22.2)	14 (45.2)	0	None	0 (0)	0	0
Married	22 (34.9)	14 (45.2)	8 (25)	1-3	33 (52.4)	19 (61.3)	14 (43.8)
Next of kin				4-6	22 (34.9)	6 (19.3)	16 (49.9)
Spouse	15 (23.8)	8 (25.8)	7 (21.9)	≥7	8 (12.8)	6 (19.3)	2 (6.2)
Child	33 (52.4)	14 (45.2)	19 (59.4)	Insurance status			
Sibling	5 (7.9)	3 (9.7)	2 (6.2)	Medicare	36 (57.1)	4 (12.9)	32 (100)
Referral source				Medicare + medi-gap	23 (36.5)	2 (6.45)	21 (65)
Trauma center	33 (52.4)	23 (74.2)	0 (31.3)	Medicaid	11 (17.5)	11 (35.5)	0
Hospital	29 (46.1)	8 (25.8)	21 (65.6)	None	4 (6.3)	4 (12.9)	0
Primary diagnosis				Other	12 (19.0)	12 (38.7)	0
Head	11 (17.5)	9 (29.0)	2 (6.2)	Admission FIM	35.2	32.36	38
Hip	20 (31.7)	4 (12.9)	16 (50)	Mean length of stay (days)	50.6 (SD 50.82)	45.00 (SD 28.65)	56.31 (SD 66.10)
Low extremity not hip	12 (19.0)	5 (16.1)	7 (21.9)	Independence in ADLs at discharge	8 (12.7)	6 (18.8)	2 (6.2)
Spine	10 (15.9)	7 (22.6)	3 (9.4)	Discharge FIM	50.24	48.84	51.65
Upper extremity not wrist	7 (11.1)	5 (16.1)	2 (6.2)	Change in FIM	14.57 (SD 14.87)	16.47 (SD 16.35)	12.66 (SD 13.22)
Other	3 (4.8)	1 (3.2)	2 (6.2)	Discharged home	47 (74.6)	22 (71.0)	25 (78.1)
Type of injury				FIM = Functional Independence Measure			
Assault	5 (8.1)	3 (9.7)	2 (6.5)	ADL = Activities of Daily Living			
Fall	17 (27.4)	5 (16.1)	12 (38.7)				
Fall down stairs	5 (8.1)	2 (6.5)	3 (9.7)				
Motor vehicle collision	30 (48.4)	20 (64.5)	10 (32.3)				

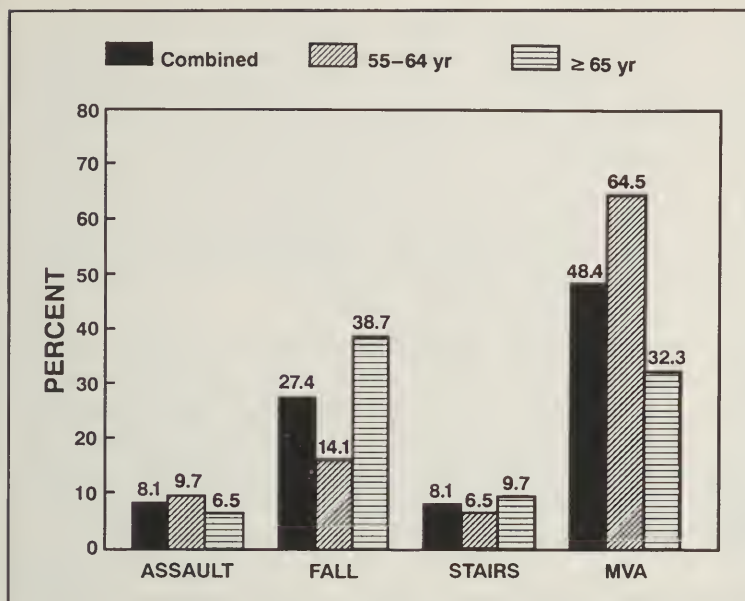


Figure 1. Mechanism of injury among 31 trauma patients aged 55-64 years and 32 patients aged 65 years or older. MVA = motor vehicle accidents.

white; most of these patients had come from general hospitals. Dominant mechanisms of injury were falls and motor vehicle collisions, in that order. The primary diagnoses were most often related to the hip and lower extremities.

The admission insurance status of the two groups is shown in Table 2B. More than one-third of the 55- to 64-year-old age group were insured by Medicaid, and 12.9 percent had no medical insurance. The over-65-year-old group was Medicare insured, with 65 percent having some secondary or medi-gap policy.

The mean ISS for the combined study population was 19.9 (SD 6.33). For the 55- to 64-year-old age group, the mean ISS was 15.0 (SD 7.1); for those 65 and over, the mean ISS was 19.91

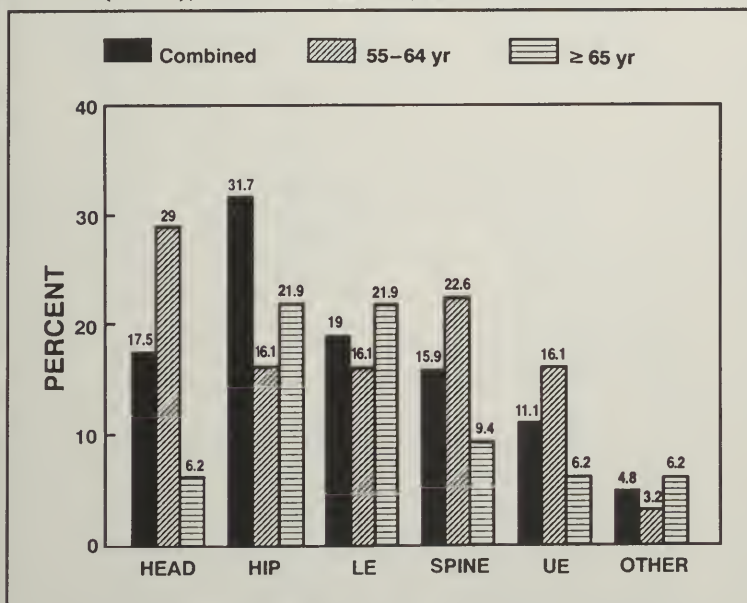


Figure 2. Primary diagnoses among 63 trauma patients older than 55 years and admitted to a rehabilitation hospital. LE = lower extremity; UE = upper extremity.

(6.3). These values are not significantly different (Table 2B).

Pre-injury cognitive impairment was recorded as being more prevalent in the younger age group (Table 2B). This age group also had a proportionally higher number of individuals with seven or more comorbidities prior to their trauma.

Admission FIM scores were slightly higher in the older group, but the over-65 group had slightly less overall improvement in functional ability than the 55 to 64 year olds (Table 2B). Only 6.2 percent of the older group was independent in activities of daily living at discharge, compared with 18.8 percent of the younger group.

Almost three-quarters of the trauma victims studied were discharged to their homes, despite the low proportion of individuals who were independent in activities of daily living at discharge (Table 2B).

FIM scores improved during hospitalization ($P < .001$) for the combined groups. The 55- to 64-year-old group's mean improvement in FIM was 16.47 units, and the 65-and-older group's mean improvement was 12.66 units, indicating no statistically significant difference in improvement between these groups.

In an effort to identify predictors of outcome, two logistic regression models were fitted. In the first, the dependent variable was disposition, dichotomized to "discharged to home" or "discharged to other." No factors were found to be predictive of disposition. In the second model, the degree of improvement in FIM was dichotomized about the median (14.4) into high-improvement and low-improvement groups and used as the dependent variable. It was believed that this was an appropriate model as few people entered with functional abilities near the maximum, so that everyone would have a chance at improving at least 14.4 FIM units. Age and number of comorbidities were included as continuous variables, and sex, occupation, marital status, next of kin, insurance status, ISS, diabetes mellitus, and pre-injury dementia were coded dichotomously (about the median value of 10 for the ISS). The results are presented in Table 3.

Six factors were found to be significantly associated with lower improvement levels. The five risk factors were male sex (except in the older group), having an offspring as next of kin (except in the older group), presence of diabetes mellitus (all groups), presence of dementia (except in the older group), and a higher number of comorbidities in the younger age group. The one statistically significant protective factor was being married (in the younger age group only).

Discussion

Only about 6 percent of our over-65-year-old population was independent in activities of daily living at discharge (Table 2B). In 1984, Oreskovich⁷ noted that

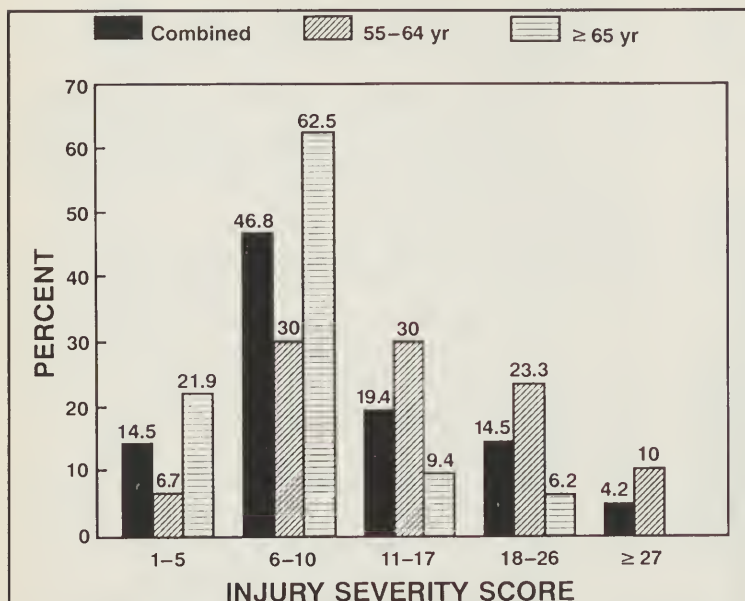


Figure 3. Injury Severity Scores for 63 patients older than 55 years and admitted to a rehabilitation hospital.

only 8 percent of his largely female study group was functionally independent one year post-injury. In 1985, Allen and Schwab¹⁶ found that only 9 percent of those discharged to home required even partial assistance, but this group consisted of those with blunt chest trauma, who might be expected to have less residual disability than those suffering predominantly limb injuries.

Since functionally dependent individuals were being discharged to their homes, it can be inferred that family or

community support sources were in place prior to discharge. Selection bias is likely to at least partially explain this finding. Those patients with strong family support or financial resources could have been preferentially considered for placement in a rehabilitative hospital. An alternative explanation is that some individuals from noncompetitive environments (i.e., already receiving care with life's necessities) were preferentially referred to the rehabilitation center. Perhaps both mechanisms were operative.

Some characteristics of the 55- to 64-year-old age group were unexpected. That upwards of 48 percent had Medicare or Medicaid as their primary insurance, along with the high rate of pre-injury morbidity, particularly cognitive impairment, leads to the conclusion that members of a medically and financially disadvantaged class were contributing to this population.

This study included patients aged 55 years and older. This resulted in a nonhomogenous study population and limits the degree to which we can compare our findings with other studies of geriatric trauma victims, which usually include those aged 65 years and older.

Some of the risk factors associated with poorer functional improvement were not unexpected. Having an offspring recorded as next of kin on a hospital admission form means either that the patient had no current spouse or that the spouse was incapable or unwilling to serve as point-of-contact. Being married at time of admission was a protective factor. This might be a measure of social function, or marital status could be a proxy for level of social support. Diabetes, cognitive

Table 3. Logistic regression results (p values)

Effect	Combined	55-64 years old	65 years and over
Intercept	0.756	0.514	0.089
Age	0.960	0.611	0.1882
Sex	0.012	0.043	0.260
Occupation	0.107	0.104	INF
Married	0.1004	0.053	0.873
Next of kin child	0.041	0.037	0.846
Insurance	0.195	0.200	
ISS	0.6685	0.26	0.315
Diabetes mellitus	0.0007	0.041	INF
Dementia	0.0167	0.037	0.9414
Comorbidity	0.156	0.049	0.688

INF = infinity, ISS = Injury Severity Score

impairment, and a high number of comorbidities are biologically plausible reasons for less functional improvement in a rehabilitative setting.

Female gender is usually associated with poorer rehabilitative outcome in the geriatric population.^{7,17} Male gender was associated with less functional improvement in our study. Although gender was not significantly associated with risk in the older subgroup, the direction of the association suggests that even males in our older group were at increased risk of poorer outcome.

In summary, this study is a preliminary investigation of geriatric trauma survivors who are referred to dedicated rehabilitation facilities. It is useful for descriptive purposes and for hypothesis generation as to risk factors associated with lesser degrees of functional improvement during hospitalization. Peculiarities of the geographic catchment area and our local referral patterns may limit the generalizability of the study.

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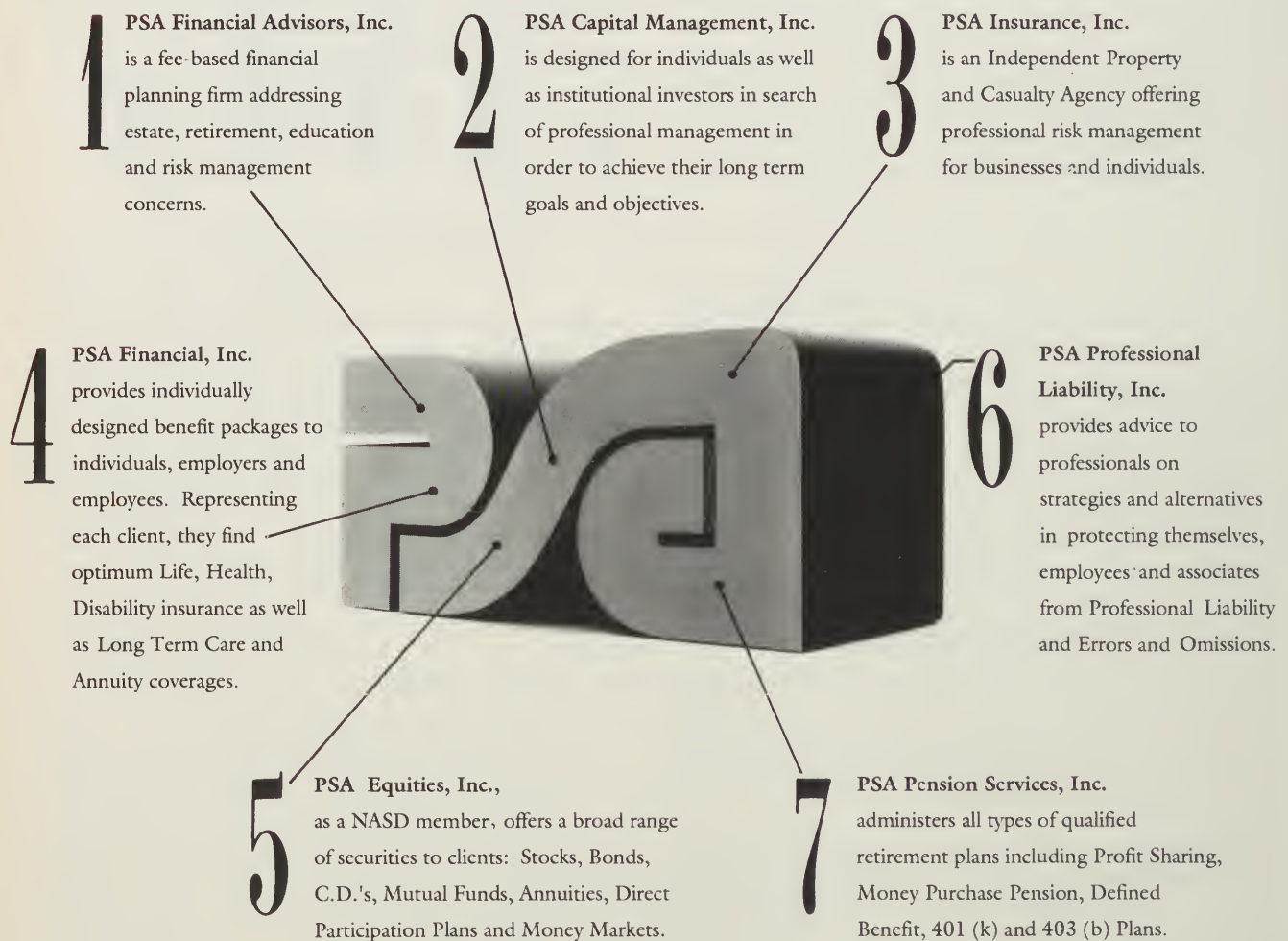
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Acknowledgments

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Ophthalmomyiasis externa: A case report

Marcos T. Doxanas, M.D.; J. Ronald Walcher, M.D.; and Rebecca A. Ludwig, M.D.

From the Greater Baltimore Medical Center where Dr. Doxanas is an ophthalmologist, Dr. Walcher is a pediatrician, and Dr. Ludwig is a pathologist. Reprints: Marcos T. Doxanas, M.D., 6565 N. Charles St., Suite 302, Towson, MD 21204.

A three-year-old white male presented with an extremely painful abscess of the nasal portion of the right upper eyelid. A larva identified as family Cuterebridae, genus Cuterebra sp, was removed from the abscess, permitting its rapid resolution. This represents an unusual patient with external ophthalmomyiasis who enjoys excellent nutritional and environmental surroundings.

Ocular myiasis is the infestation of the eye or ocular adnexa by the dipterous or fly larva. Behr¹ has distinguished three types of ocular involvement: ophthalmomyiasis externa, interna anterior, and interna posterior, indicating involvement of the ocular adnexa, the anterior chamber, or the posterior segment, respectively. This unusual affliction is encountered most frequently in tropical areas associated with poor environmental conditions and hygiene. The authors evaluated a three-year-old male with ophthalmomyiasis externa presenting as an abscess of the right upper eyelid, which was secondary to a botfly larva.

Case report

A three-year-old male was referred for evaluation with a one-week history of a right upper eyelid abscess. The child's height was 40.5 inches, which is in the 75th percentile. His weight was 50 pounds, which is in the 50th percentile. The patient was well nourished. He lived in Baltimore County but did not live on or have occasion to frequent a farm. His abscess was nonresponsive to Keflex (cephalexin) and Ceclor (ceclor). Three weeks prior to presentation, the parents noted a migratory impetigo starting at the right lip and slowly proceeding to the right upper eyelid. The eyelid was indurated and extremely sensitive to palpation. Two days prior to presentation, the patient began to awaken from naps crying hysterically, apparently due to pain in the upper eyelid.

It was initially assumed that the patient had a localized right upper eyelid abscess or possibly a ruptured dermoid cyst, which infrequently occurs in the nasal aspect of the orbit. He was continued on Ceclor and started on erythromycin ointment and warm compresses. The warm compresses precipitated episodes of extreme discomfort and could not be continued. One day after presentation, the parents reported pulling a "worm" from a small epithelial defect in the central aspect of the abscess (Figure 1). After removal of the worm, the patient's pain rapidly subsided, and the abscess slowly resolved. Within one week, the inflamma-



Figure 1. Abscess of the right upper eyelid in a 3-year-old male. Note the central epidermal defect, which was the site of exit of the larva.

tion and abscess of the eyelid had totally resolved. The specimen was identified as a larva belonging to the family Cuterebridae, genus *Cuterebra* sp (**Figure 2**). Unfortunately, the larva was not fully developed, requiring additional molts before the species could be identified.

It should be noted that the patient had infrequent contact with animals. His last visit to the Baltimore Zoo was approximately three months prior to presentation.

Comment

Ophthalmomyiasis is an unusual condition, most commonly encountered in tropical countries with low standards of hygiene. Garzoni and coworkers² reported 27 cases of external ophthalmomyiasis in a two-year period in Israel. Human infestation generally occurs following bites by mosquitos or flies that carry botfly larvae on their abdomen. The eggs, if implanted into the skin, require 50–100 days to mature into larvae.

Digestion of tissues permits larval growth and maturation. At the larval stage, migration may occur. If superficial, migratory tracts can be realized. This probably occurred in the patient reported herein as a migratory impetigo from the upper

lip to the right upper eyelid. Atypical cutaneous lesion consists of a painful dome shaped indurated nodule with a central orifice that allows the larva to exit the abscess to breathe. The vast majority of the larvae identified in the ocular adnexal area are *Oestrus ovis*—the sheep or goat botfly.³ *Calliphora vomitoria*, *Hypoderma bovis*, and *Callitroga macellaria* larvae may produce a destructive infiltration of the eye and internal structures.^{4–6} Migration of the larvae to the subretinal space will produce migratory tracts, pathognomonic of subretinal ophthalmomyiasis.⁷

Cuterebra is a genus of large bee-like flies that develop individually in the skin of rodents and rabbits. The full-grown larvae are covered by black spines and may measure over one inch in length. The younger larvae have only rings

of spines (**Figure 2**), which devitalize living tissue for consumption by the larvae. It is these spines, as well as toxic excretory products of the larvae, that produce the severe pain and inflammation of the cutaneous lesion. *Cuterebra* larvae have been previously reported in the ocular adnexal area.^{8–10}

Therapy for ophthalmomyiasis generally consists of surgical or mechanical removal of the larva. As in the reported



Figure 2. Larva identified as *Cuterebra*. The rows of black spines devitalize tissue for larval consumption.

patient, rapid resolution of the lesion then occurs. If the abscess does not resolve, additional larvae or remnants of the larvae may remain, necessitating surgical exploration. Additional suggested therapy includes topical application or injections of toxic substances such as alcohol or ether to devitalize the larvae.

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THE MARK OF EXCELLENCE

Two centuries of medical organization and licensure in Maryland

Joseph M. Miller, M.D.

Dr. Miller is a retired surgeon from Timonium, Maryland.

In 1766, the first American medical society was established in New Jersey. It was not until 1968, more than 200 years later, that the state medical societies would finally mold a satisfactory means of medical qualification and licensure.

During almost the entire period of colonial America, doctors were mainly prepared for practice by serving an apprenticeship and by "reading medicine," although some of them went abroad to study. Apprentices usually had little time for study and learned what they knew from contact with their preceptor. The first American medical school was the College of Philadelphia (now the University of Pennsylvania), established in 1765, followed by the College of Physicians and Surgeons (Columbia) in 1769, and by Harvard in 1785.¹ Because education in general was poor, diagnosis and treatment were frequently not optimal. After the Civil War, a great number of medical schools were formed and, by 1900, more than 400 existed in the United States.² Few of these institutions were associated with universities, and many of them were proprietary in nature. Education was entirely didactic without recourse to teaching aids, laboratories, and systematic methods of instruction.

Medical societies were one method for correction of this inadequate manner of providing knowledge. To achieve this end, they first had to be created and molded into institutions exerting a proper force. Although organized cooperation is now recognized as necessary for the ultimate well-being of any enterprise, union among the physicians of Maryland was long delayed. According to Billings, the order of formation of the early societies was New Jersey, 1766; Massachusetts, 1781; Delaware and South Carolina, 1789; New Hampshire, 1791; Connecticut, 1792; and Maryland, 1799. An even greater procrastination occurred on the national level as the American Medical Association (AMA) was not formed until 1847. In 1839, the New York Medical Society had recognized the evil that might exist between teaching and licensing and resolved that they ought to be separated. Further discussion led to a convention of delegates from the medical schools and the state societies, which resulted in the formation of the American Medical Association. (The AMA's first annual convention was held in Baltimore in 1848.)

Medical societies have always influenced the progress of medicine in a positive way and have enhanced relations among doctors and between doctors and the public. The societies were the principal catalytic agents

defining and refining the standards of medical education. The criteria of the societies became those of the medical schools.

Maryland took an early lead in attacking the problems of medical reform and the prevalence of quackery, as these were subjects of concerned discussion by physicians as early as 1786-1788.³ These deliberations led to a meeting in December 1788 at Stark's Tavern in Baltimore to formulate a plan for the creation of a state society and for the regulation of medical practice. A Maryland association was effected and officers elected. (Baltimore doctors had formed a local group in November of the same year.)

Although these efforts at organization were temporarily aborted, they did have permanent value inasmuch as the seed for improvement was planted. A decade later, state physicians, in a united effort, witnessed the incorporation of the "Medical and Chirurgical Faculty of the State of Maryland" by a legislative act dated January 2, 1799.⁴ Members of the legislature believed that "beneficial and salutary consequences would ensue as medical and surgical knowledge would be promoted and disseminated."

The first Monday of the following June was designated as the time of the initial meeting of the new society. The act also empowered the society to elect, by ballot, 12 persons to serve as "The Medical Board of Examiners for the State of Maryland." Seven members were to be residents of the western shore and five of the eastern. Thus, an examining board with the power to grant certificates was created. Individuals, not already in practice were legally barred from such activities until licensed.

The called meeting was held in Annapolis in June, and 101 incorporators representing each of the 19 counties and the cities of Annapolis and Baltimore were present. Officers of the society and members of the Board of Medical Examiners were chosen. The incorporators of the new group epitomized the best elements of the Maryland profession at that time, with many of them having been trained in European medical schools.

Calmness and reason pervaded the medical scene until legislative action granted authority to Thomsonians or Botanic physicians to practice medicine. (A book with the title of *Families' New Guide to Health; Together with an Exposition of the Thomsonian Preparations of Medicine* appeared in Baltimore in 1833. The Thomsonian sect had arisen in New England and its persevering promotion in Maryland led to the passage of this astounding act by the legislature in 1839.)

"Be it enacted by the General Assembly of Maryland, That from the passage of this act, it may be lawful for each and every person, being a citizen of this state, to charge and receive compensation for their services and medicines in the same manner as physicians are now permitted to do."⁵ The act virtually repealed the 1799 charter of the medical society by depriving it of its functions, which had been exercised for community benefit for 39 years. The entire body of physicians in the state were lethargic about the matter, and attempts to appeal to the legislature or test the validity of the law in the

courts were not made. Proper licensing of professionally educated doctors was effectively ended by the 1839 act.

This apathy ended in 1867 when evidence of a revival were observed. Concerned physicians secured an act from the legislature, founding an entirely new state medical society with full power to control medical practice.⁶ The legislature was perturbed by the evidence that many persons were practicing medicine, surgery, and obstetrics without proper medical education, and that certain individuals were notoriously engaged in the unlawful procedure of abortion. Temporary medical board examiners were appointed for each district by the governor to function until a permanent board could be assembled. The licensed physicians constituted the medical faculty of the state of Maryland.

The environment again changed for the better in 1888 when the General Assembly enacted a bill stating that every person practicing medicine in the state must possess a license.⁷ Graduates of reputable medical colleges had to appear before the State Board of Health, present their diplomas, and state by affidavit that they were the person named therein. Another indication of improvement was the provision that certification could be refused by the Board of Health if the colleges or schools from which the individuals had graduated were not in good standing or if the individuals themselves were suspect and did not measure up to proper standards. Those individuals who were practicing but were not graduates of an acceptable medical school had to appear before the board for an examination. This act corrected some of the errors of the act of 1838 but was not yet entirely satisfactory.

In 1892, chapter 296 of the Laws of Maryland attempted further improvement.⁸ Two separate boards of medical examiners, one representing the Medical and Chirurgical Faculty and one the Maryland State Homeopathic Society, were created. Each board consisted of seven members. Individuals associated with colleges or universities and physicians with a primary interest in the trade of pharmacy could not serve on these boards. Examinations in specified fields were to be conducted by the boards.

In 1957, the General Assembly abolished the homeopathic board and provided for the State Board of Medical Examiners to regulate the practice of medicine.⁹ Gradual improvement in the procedure and regulation of licensing occurred.

Malpractice has existed since the earliest days of the state medical society as shown in the meeting of 1802 when an announcement was made that many individuals were practicing without a license. Censors, appointed to see that the law was not infringed by unlicensed practitioners, were continued as a part of the machinery of the medical society for about 50 years. Some offenders were brought to justice, but the main thrust of the group was the threat of legal prosecution and its salutary effect on the violators.

The censors of 1802 were revived—in a way—by an amendment to the Maryland Practice Act, which, in 1988, substituted the State Board of Quality Assurance for the State Board of Medical Examiners.¹⁰ All 15 members were to be

appointed by the governor. Ten were to be practicing licensed physicians from a list submitted by the medical society, one was to be a representative of the Health Occupation Department nominated by its secretary, two consumer members were to be appointed with the advice and consent of the senate, and one consumer member was to be nominated from a list submitted by the Maryland Hospital Association. Certain qualifications for consumer members were carefully delineated.

Maryland and its sister states have traveled far from the eighteenth and nineteenth centuries when physicians were licensed by independent, degree-awarding medical schools, medical societies, and individual states. A fragmented state-by-state licensing system persisted into the twentieth century. Efforts were then made to establish a national examining board, and the National Board of Medical Examiners was created in 1915. Individual states could not or would not agree on a common standard, so that the national board became a qualifying board and not a licensing authority. In 1968, a federal licensing examination acceptable to all states was in effect. By trial and elimination, the state medical societies, of which Maryland was one, had finally molded a satisfactory means of medical qualification after a period of about two hundred years.

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Sir William Osler—Contrasts between the saint-like legend and the rough-edged man

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Sir William Osler, the first physician-in-chief of the Johns Hopkins Hospital and later Regius Professor of Medicine at Oxford, is judged by many to be the greatest clinician of the modern era. His life history of distinguished service to medicine and to society is well known. What is not so well known is his mischievous streak

William Osler was the man who single-handedly carried the torch of medicine from Europe to the new world in the latter decades of the nineteenth century. With the publication of his *Principles and Practice of Medicine*, he established himself as the new world's Hippocrates and Galen wrapped into one charismatic personality. His textbook was published in 1892. It rapidly became the standard medical student textbook and was later translated into numerous languages.

His success as one of the great medical educators of his time lay not in his original contributions to science. Osler's major contribution was his profound influence on everybody with whom he came into contact, especially his students at McGill University, the University of Pennsylvania, Johns Hopkins, and Oxford University. Osler influenced and inspired people with his humility, good humor, and equanimity. And, according to his contemporaries, what made him special was his sympathy, empathy, and intimate understanding of the problems and responsibilities of students. More recently, many have wondered about the secret of his power over people and the real nature of the man.

His biography is well known. He was born July 12, 1849, the eighth child of Ellen Pinckton and the Reverend Feathstone Lake Osler at Bond Head at the edge of the upper Canadian wilderness. His father, the Reverend Osler, was a pioneer, Anglican clergyman, and missionary. Osler was raised in a religious household in which the major concern was education for which no expense was spared. He was bright and industrious. His father encouraged him to follow him into the clergy, but Osler, the boy, had an inclination to mischief that undoubtedly disqualified him in his own mind. The young Osler came under the influence of his Uncle Edward who had come to Canada from England as an accomplished naturalist. Edward Osler became a local literary figure who wrote poetry and hymns as well as scientific articles and biologic studies.

William Osler attended school in Dundas, Ontario, where there were many reported instances of his practical jokes. After one too many, he was expelled. He then attended the Barrie Grammar School, a strict

boarding school in Barrie, Ontario. After one year, he was sent to the Trinity College School in Weston, Ontario where, at the age of sixteen, Osler first became serious about higher education. His streak of mischievousness continued, and on one occasion, various school pranks put him in jail for at least two days.

At Trinity, Osler came under the influence of the Reverend William Johnson, headmaster of the school, who recognized young William's potential. Reverend Johnson, like Osler's Uncle Edward, was an avid naturalist interested in collecting biologic specimens and classifying them with the aid of his microscope. He also possessed that charismatic ability to inspire students to think for themselves. Another Anglican clergyman, the Reverend James Bovell, who taught histology at the University of Toronto Medical School and was the school physician, also had a major influence on Osler. But it was Father Johnson—who loved the writings and philosophy of Sir Thomas Browne—who introduced Osler to the *Religio Medici*, which was to become his lifetime bedside companion.

After graduating from Trinity College School, Osler went to Trinity College in Toronto for one year before enrolling in medical school at the University of Toronto. At this time, the influence of James Bovell was very great. While working with Bovell, Osler learned the fine points of microscopy and tissue preparation.

Osler continued his education at McGill University, which he entered at age 21. At McGill, he encountered Robert Palmer Howard, another charismatic teacher, who was to have the greatest influence over him. After graduation from McGill in 1872, Osler went to Europe for two years of postgraduate study. For over a year he worked in London at the University Hospital. Afterwards he traveled to Berlin and Vienna to study under the great Virchow and Rokitansky, the greatest pathologists in Europe.

After a short time in practice, Osler joined the faculty at McGill University. In 1884, he was invited to take the chair in clinical medicine at the University of Pennsylvania. There he introduced new methods of teaching and clinical investigation based on his European experience. By 1889, his growing reputation had reached Baltimore, where the faculty of the newly founded Johns Hopkins School of Medicine was being selected. At the suggestion of John Shaw Billings, a member of the Johns Hopkins board, Osler was chosen for the chair in clinical medicine at the relatively young age of 40. Shortly thereafter, he married Grace Revere Gross.^a It was at Hopkins where he came into full flower and implemented his new ideas of ward teaching and resident training. It also was there that he formed his most lasting relationships with the other young service chiefs—Welch^b (39) in pathology, Kelly^c (31) in gynecology, and Halsted^d (37) in surgery. These physicians

Notes —^a Grace Linzee Revere (1854–1928), the great granddaughter of the American patriot Paul Revere, was born in Boston. At age 22, she married Dr. Samuel W. Gross, a prominent Philadelphia surgeon, whose father, Dr. Samuel D. Gross, was the greatest American surgeon of the era. After 13 years of marriage, her husband died. William Osler was a close friend of the Gross family during his five Philadelphia years and married the Widow Gross three years later in 1892 when Osler was 42 years old. The story of their wedding day may shed some light on the character and personality of both husband and wife: “Shortly before lunch a friend, James Wilson, dropped in, and finding Mrs. Gross and his former colleague [Osler] sitting under a tree in the garden, remarked: ‘Hullo, Osler, what are you doing over here? Won’t you have lunch with me?’ ‘No,’ said Osler, ‘I’ll come in to tea. I’m lunching here. Why don’t you stay?’ They chatted for some time, until presently Mrs. Gross asked to be excused, with the statement that she was going out and a hansom was waiting at the door, whereupon Wilson made his manners, pleading an appointment, leaving Osler, who said that Mrs. Gross would give him a lift as she was going in his direction.... Leaving their bags at the station, they drove to St. James Church, where the ceremony was performed, and having walked back to take their train, Osler sent this telegram to Wilson: ‘It was awfully kind of you to come to the wedding breakfast.’”

Grace Osler was a most unusual woman, eminently capable of bearing Osler's erratic habits and complicated schedule. They always had servants, which simplified life, but the strains must nevertheless have been severe. Osler often would come home to 1 West Franklin Street with unexpected guests—sometimes many unexpected guests. Pratt⁴ remembers that “Mrs. Osler told me she never knew how many men he would bring home for luncheon. It might be only two or it might be six.”

^b William H. Welch, M.D. (1850–1934) received his M.D. from the College of Physicians and Surgeons in New York in 1875. He taught the German methods of medical science in New York from 1876 to 1884 and, although already appointed professor of pathology at Johns Hopkins, he studied bacteriology in Germany from 1884 until 1885. At Hopkins, he was professor of pathology for 33 years, director of the School of Hygiene and Public Health from 1920 to 1929, and professor of the history of medicine from 1929 to 1934.

^c Howard A. Kelly, M.D. (1853–1943) was a lifelong friend of Osler starting in his early Philadelphia days and while professor of gynecology at the University of Pennsylvania (1888). He became the first professor of gynecology at Johns Hopkins (1889–1919), with Osler's strong approval, and established long-term residency training in gynecology. Through his famous pupils, his innovative operating techniques, and his talented methods of education using demonstrations, stereo-optic photographs, and publications, he attained a leading position in gynecology. He contributed to medical history and biography, and participated actively in religion and philosophy.

^d William Stewart Halsted, M.D. (1852–1922) received his M.D. at the College of Physicians and Surgeons in New York in 1877. He trained in Vienna and German clinics between 1878 and 1880. He operated and taught at the College of Physicians and Surgeons from 1880 until 1885. After conducting surgical research with Welch and Mall at Johns Hopkins, he became the first surgeon of the Johns Hopkins Hospital in 1889, and was a professor of surgery from 1892 until 1922. Halsted developed surgical procedures only after detailed animal studies. He advanced techniques for cancer of the breast, inguinal hernia, and other areas. He taught meticulous dissection with aseptic technique and control of all bleeding vessels. His experiments led to the introduction, in 1885, of block anesthesia with cocaine, to which he developed an addiction that haunted his entire life. William Osler recounted this tragedy in a very sympathetic manner in his own diary later published by Penfield.²⁶ His relationship with Osler may be exemplified by this story by James F. Mitchell.²⁷ “We all admired the spirit of comradeship that existed among our professors, whom we considered old men although they were all in their forties. Dr. Osler was the particular tease. During operations, three Arnold sterilizers were on a table beside the nurse—one containing sponges, another towels, and the third dressings.

Dr. Osler would come in and ask, ‘Halsted, what are you doing?’

He [Osler] would put his cane or umbrella in one sterilizer, his gloves in another, and his hat in the third, and then walk around to get a good view of the operation.

Dr. Halsted would say, ‘Osler will you never grow up?’ and that was all.”

made up the Hopkins Big Four. All were great innovators in teaching and research and, in only a few short years, were thrust to the most dominant position in American medicine.

Osler died September 29, 1919. In *Lancet's* obituary, he was called "the greatest personality in the medical world." Edith Giddings Reid stated, "To those he cared for on earth he brought life. We will look back and remember that for us was the high privilege of having seen and felt power without evil, a transcendently beautiful life."

Power without evil? How then does one explain the difference between the legend of Osler with the refined image shaped by his writings and speeches and the man who committed cruel deeds and showed his rough edge more than once. How also to explain this lifelong, mischievous streak of nasty, practical jokes that he engaged in throughout every phase of his career. In childhood, it is stated that his family laughed at his shenanigans. His father thought that Osler could do no wrong, especially against "those Methodists who controlled the school" that expelled him. His father named him for William of Orange (the anniversary of his "great victory over the Catholics" occurred on Osler's birthday). His mother was more concerned with Osler's not returning thank-you notes than with "suffocating" teachers. In fact, at age 5, he was only mildly reprimanded for cutting his sister's fingertip with a hatchet.

To the world, to his students, to his disciples, and to his biographer and protégé Harvey Cushing,^e Osler was a saint. Cushing¹ wrote after Osler's death, "In the first shock of grief at the news of Sir William Osler's death, it is difficult for anyone who felt close to him to say what is in his heart. And the strange thing about this unusually gifted and versatile man is that everyone fortunate enough to have been brought in contact with him shares in this feeling of devotion, for he gave of himself much to all. This was true of his patients, as might be expected, and he was sought far and wide not only because of his wide knowledge of medicine and great wisdom, but because of his generosity, sympathy and great personal charm. It was true also—and this is more rare—of the members of his profession for whom, high or low, he showed a spirit of brotherly helpfulness untainted by those petty jealousies which sometimes mar their relationships. 'Never believe what a patient may tell you to the detriment of another physician—even though you may fear it is true,' was one of his sayings to students, and he was preeminently the physician to physicians and their families, and would go out of his way

unsolicited and unsparingly to help them when he learned that they were ill or in distress of any kind..." Reading about Osler is almost like reading about a god. A human being, yet an angel, bigger than life, floating above it all, as in the 1896 drawing of Osler by Max Brödel.

Osler's portrait suffers from the accumulation of layers of time. With each decade another layer of legend and anecdote results in the re-shaping of the godlike Osler. As pointed out by some, this is a clay god. His saint-like image originated with Osler's mother and, later, his wife, who made sure that Harvey Cushing's biography of Osler did not include any possible negatives. This godlike persona was amplified by Giddings and others.

Osler could preach, like Jesus, to think well of one's fellow man, obey the Golden Rule, and never talk against one's fellow physician but, he had his moments. Roland³ describes him in *Osler's Rough Edge* as being mean in public to a fellow physician as well as to an elderly secretary of the American Medical Association.

Even Osler's old mentor, the Reverend William Johnson,² wrote to his son, who was studying medicine at McGill University under Professor Osler, "...I am not surprised at your not taking up with Professor Osler. He is an Osler and there is that in him, unless I am much mistaken, which you must never admire.... I would like to write you a good deal on the Osler character, but am too poorly.... There does not appear to be any talent about them or any high principle of action. Simply great application and, probably, the motive is money making."

Osler did not hide much of himself from public scrutiny—not even his dreams, which he wrote down and knew would be published after his death. Nor did he worry about what his postmortem examination would show; he ordered it to be done despite nervously joking that it might reveal syphilis.

Roland,^f one of Osler's admirers, provides a balanced view of the man when he writes of Osler's rough edge:³ "...let me quote two sentences that are by no means atypical of writings about Osler. Pratt wrote,⁴ 'He would not listen to gossip nor was he known to speak ill of anyone.' And again: 'He was always sincere, always charitable, always striving to bring happiness to others...' Yet in that same volume, Pratt [also] related an account of Osler blackballing a candidate for membership in the Association of American Physicians. Pratt knew of no other physician who was denied membership. But he wrote, '...Osler arose in the audience to oppose the election

^e Harvey William Cushing, M.D. (1869–1939), an American surgeon, was a fourth-generation physician. After graduation from Yale University and Harvard Medical School, he spent four years at Johns Hopkins Hospital under the influence of Osler. He also knew Welch and Halsted very well. Following study abroad, he returned to the Hopkins faculty in surgery. From 1917 to 1919, he was director of the US Base Hospital No. 5 and was present in France at Revere Osler's death from battle wounds. His *From a Surgeon's Journal* (1937) is a fascinating diary of his war experiences and describes the details of Revere Osler's death, the only child of William Osler. In 1917, *The Life of Sir William Osler* (1925) was

awarded the Pulitzer Prize for biography. He was professor of surgery at Harvard Medical School from 1912 to 1932 and, in 1933, became Sterling Professor of Neurology at Yale University.

^f Charles G. Roland, M.D. was born in Winnipeg, Canada in 1933. Dr. Roland graduated from the University of Manitoba in 1958. After several years of medical practice, he became a senior editor of the *Journal of the American Medical Association* in 1964. In 1969, he became chairperson of the Department of the Medical Library and of Publications at the Mayo Clinic and Mayo Foundation.

of one of the nominees, who, he stated, was only a second-class general practitioner.' His charge may have been accurate. Likely it was. But was this the same man who was never known to speak ill of anyone?"

As Osler⁵ himself said, "...it may be sufficient to remind this audience made up of practical men, that the word of action is stronger than the word of speech."

Let us examine Osler's actions as reported by Roland.³ "On another occasion, in 1985, Osler disrupted a meeting of the American Medical Association [AMA]. The organization convened in Baltimore that year. At the time, Dr. William B. Atkinson had been secretary for 31 years.⁶ The secretaryship was then a permanent office, held in perpetuity unless two-thirds of the AMA members voted otherwise. When another member eulogized Atkinson, appealing to the assemblage to 'let us try and make him feel happy,' Osler spoke out. He even stood on his chair, the better to be heard,⁷

...Let the quality of mercy be not strained. I stand here and say plainly and honestly before Dr. Atkinson what I and many other members have said behind his back, that he is not an efficient secretary of this association, and that we have not found him so. (Hisses, followed by applause.) You may hiss if you will, but I unhesitatingly say that no more important step in advance will be taken by this association than when it changes its secretary."

As further documentation of Osler's real life rough edge, Roland² also writes that "The author of one book reviewed by Osler and exposed to his rough edge possibly never wrote a second. Here in its entirety is Osler's⁸ meat axe critique of the author's maiden effort.

This work, the author tells us, was suggested by his own necessity; for after reading all the modern works on the subject, he felt that there was wanting a small, handy manual suitable for the general practitioner and student. We sincerely trust that active professional duty at High Wycombe will prevent his reading all the modern works on any other subject, lest a similar compulsion should seize him, and result in the production of another such dull, toneless compilation as the present volume."

Roland² also relates that "He (Osler) could rattle the same sword at his students, too. At the dedication of Old Blockley, McFarland⁹ recalled Osler reviewing a patient who had cirrhosis of the liver.

After all phases of the disease had been dwelt upon and the treatment reached, he [Osler] turned to one of the students and said, 'Now, what shall we do for this man?' The student remembering instruction received in other departments, unhesitatingly responded, 'Administer potassium iodide to absorb the connective tissue in his liver.' Assuming an erect and somewhat belligerent attitude and emphasizing each word with an extended forefinger, Osler said, 'You might as well administer iodide of potassium to absorb a lead pencil in the man's vest pocket as to absorb the connective tissue in his liver.'

Osler himself acknowledged these shortcomings. Certainly, he had this in mind when he said,⁵ "It may be that in the hurry and bustle of a busy life, I have given offense to some—who can avoid it? Unwittingly, I may have shot an arrow over the house and hurt a brother—if so, I am sorry, and I ask his pardon. So far as I can read my heart I leave you in charity with all."

One of Britain's greatest classical scholars, Sir Frederick Kenyon, wrote that "Osler was a well nigh perfect example of the union of science and the humanities." And in another tribute, Harvey Cushing stated, "Sir William Osler was a man first—a physician and a scholar afterward; and beneath his high spirits, his love of fun, lay an infinite compassion and tenderness towards his humankind."

But, there is no question that Osler engaged in knocking his colleagues. Perhaps the reason for this is found in an address justifying a vigorous state medical society. Osler¹⁰ stated that "no class of men need friction as much as physicians.... The daily round of a busy practitioner tends to develop an egoism of a most intense kind, to which there is no antidote. The few setbacks are forgotten, the mistakes are often buried, and ten years of successful work tend to make a man touchy, dogmatic, intolerant of correction, and abominably self-centered... a man misses a good part of his education who does not get knocked about a bit by his colleagues in discussions and criticisms."

Be that as it may, Osler really loved his fellow man. He particularly loved children, and clinical rounds usually ended on the pediatric ward. Children would listen for his coming and going. His favorite trick was to put a penny on the umbilicus of a bedridden youngster with a promise that, "If you keep it there until next Sunday, there'll be two." Osler made sure that a nurse would fix the penny in place with adhesive and place another one there later when the child was asleep. Another trick of his was to tiptoe into the pediatric ward and cover the head nurse's eyes with his hands, saying in a gruff, bear-like voice, "Guess who's here?" to the squeal of laughter of the youngsters in the ward.

Hurd,¹¹ another Osler biographer, wrote, "Fancy the difficulty of only impressing high moral precepts upon the young in the light of such a confusing example. Children delighted in his presence and were charmed by him. But very naturally (they) were always uncertain as to the logical nature of his conclusions and equally puzzled by his apparent indifference to conventional conceptions of duty and obligation. There was also in his attitude toward pupil nurses a similar light-hearted irresponsibility. It is possible, however, to perceive that under the cloak of these apparent trivialities there lurked a seriousness of purpose and a keen desire to point a painful moral in a kindly way. With children, however, it was simply an expression of his ample imagination and of his desire to please and puzzle them."

Hurd⁸ may not have been familiar with Lewis Carroll's novels—*Alice's Adventures in Wonderland* (1865) and *Through the Looking Glass* (1872)—nor heard about all the other tall tales Carroll told Alice Liddell, the daughter of an Anglican prelate, but it is probably certain that Osler did. Davison writes,¹² "For example, at a tea, a loud-voiced American woman rudely asked him [Osler], 'Do you prefer

⁸ Henry Mills Hurd, M.D. (1843–1927) received his M.D. at the University of Michigan (1866). He was superintendent of Eastern Michigan Hospital for the Insane in Pontiac, Michigan (1878–1889). He later became

superintendent of Johns Hopkins Hospital (1889–1911), and then secretary of the Board of Trustees of the hospital.

being called Sir William or just plain American Dr. Osler? He smilingly quoted Lewis Carroll's *The Hunting of the Shark*: 'I answer to Hi or any loud cry' without hurting her feelings."

Osler often had bouts of melancholy or depression, but his "ready wit and ever present sense of humor led often to practical jokes." When two of his young trainees opened an office next to his on Charles Street in Baltimore, they returned one day to find a sign on their lawn which read, "these young fellows are novices—come next door."

What was the cause of his flighty and quixotic behavior—the melancholy vs the humor? Maybe he needed these episodes of practical jokes to balance his "gravitas" or perhaps he used these incidents as an escape from secret sorrow or hidden tragedy. Maybe his imposed inappropriate affect was used to snap out himself of his depressions. Sometimes, according to Hurd,¹¹ "...people were sometimes at a loss to follow his moods and strange fancies. He was invariably cheerful, hopeful, and optimistic even under circumstances of discouragement and doubt. I remember on one occasion, one of his colleagues, mystified by his imperturbability in a trying emergency said, 'Osler drop your mask, let us know what you actually think of the situation.' But no one ever did gain that knowledge."

Perhaps a clue can be found in the apocryphal story in which Osler was asked why he whistled as he walked along hospital corridors, he replied, "I whistle that I may not weep."

Sometimes his jokes took on an outrageous turn. He enjoyed writing up outlandish tall tales true or not.¹³⁻¹⁸ Perhaps a perfect example of the length Osler would go to carry out a practical joke is exemplified by this story by William D. Tigert¹⁶ and documented by Cushing and others. "Osler attended the 1896 meeting of the American Pediatric Society in Montreal. Also present was Thomas Morgan Rotch, M.D., professor of pediatrics at Harvard University, who three years earlier at the meeting of the same society in Boston had presented a paper¹⁹ on 'The value of milk laboratories for the advancement of our knowledge of artificial feedings.' Osler had commented on this paper. Rotch had set up facilities for the feeding of Bostonian infants on milk from carefully selected cows, and had arranged to have the amounts of fats, carbohydrates, and proteins varied, on a day-to-day basis, by compounding the product in the way that druggists filled prescriptions. Such a practice according to one reporter, would have impressed Osler as 'sheer impracticable lunar therapeutics.' [He also looked at this more as a commercial venture to enrich Rotch than having any scientific merit.]

"It happened, at the Montreal meeting, that Osler and Rotch were sitting next to each other at a dinner. Stories differ as to how the subject was introduced, but all agree that Osler, at some time during the evening, captivated Dr. Rotch and his wife with a discussion 'of a nearby ideal village, with a perfect child-welfare health centre, where the artificially-fed infants were all nourished on certified milk, and the social conditions were faultless. The name of the place was Caughnawaga, and he described minutely how to drive by cab to Lachine and hire a boat to row across the river to this jewel in the wilderness.'²⁰

"It had been built (said Osler¹⁸) by an American Army Surgeon, E.Y. Davis (a pseudonym often used by Osler), with schoolhouses, parks, theatres, paved streets, and a fine hospital. [Cushing⁷ reports that] 'Rotch, with his wife, followed out Osler's instructions the next day and (after a very exhausting trip) eventually arrived at the obscure Indian village of Caughnawaga (to find nothing). Rotch never forgave Osler.'"

Osler also relished the idea of trying to shock his own personal physician. Once when Osler had a bout of renal colic, he handed his physician, Thomas B. Futcher,^h a jar containing his urine specimen in which the microscopic examination was grossly clear except for an occasional red blood cell. One bottle contained several large quartz stones gathered from the gravel walk.²¹

During Osler's years in Baltimore, he was known for stuffing embarrassing objects into the pockets of a clergyman leaning over the umbrella rack at the Athenaeum Club. Also, he was not above snatching a nurse's purse on a streetcar and paying everybody's fare, only to return it the next day with a note of apology (but without the money).

These jokes extended even to his own wife, a proper, well-mannered socialite with a strict Victorian upbringing who, on occasion, was severely embarrassed to find that her husband had signed the hotel register for their hotel room as "Mr. Egerton Y. Davis and Mrs. William Osler." This was 100 years ago when society's outlook on such matters was vastly different from today.²²

Osler had no inhibitions about playing jokes on the very famous. Dr. Joseph Prattⁱ related an eyewitness report²³ of Osler at a luncheon at the University Club of New York. "Once I was present at a luncheon at the University Club in New York which Dr. Osler gave during a meeting of the American Association of Pathologists and Bacteriologists. The other guests were Dr. Councilman, Dr. J. G. Adami of McGill University, and Dr. William MacCallum^j of Johns Hopkins. It was MacCallum who started Dr. Osler off by

^h Thomas Barnes Futcher, M.D. (1871–1938) earned his M.D. in Toronto in 1893. He married a favorite of Osler's, Gwendolen Marjorie Howard, in 1909. She was the daughter of Osler's mentor, Robert Palmer Howard. (Their son, Palmer Futcher, whom I've known for 30 years, was good enough to review much of my articles on Osler. He now lives in Philadelphia with an academic appointment at the University of Pennsylvania. He has published Osler's letters to his mother: Futcher PH. Letters of William Osler to Marjorie Howard. Shared Courtship, Family and Bereavement. *Trans Stud Coll Physicians Phila* 1990; 12(4):413–43.)

Futcher was a house officer, Toronto General Hospital, 1893–1894, associate resident, 1894–1898, and resident on Osler's medical service, Johns Hopkins Hospital, 1898–1901. He practiced in Baltimore until his death.

ⁱ Joseph H. Pratt, M.D. (1872–1956) earned his M.D. at Johns Hopkins in 1898. He trained in pathology at Harvard under F.B. Mallory and W.T. Councilman from 1898 through 1902 and spent a lot of time with the Oslers at their house on West Franklin Street from 1896 to 1897.

asking the name of this delicious fish we are eating. 'It is scrod,' said Dr. Osler. 'Scrod!' said Dr. MacCallum. 'I never heard of it.'

"You know what a capon is; scrod is codfish that has received the same treatment. The production of scrod has become a thriving industry along the New England coast, as Councilman knows.' Osler then went on to describe in detail. 'The cod come up inlets from the sea in great numbers in the spring and are diverted into narrow, shallow troughs, from which they are removed by the nimble hands of trained workers, who quickly and skillfully castrate them. They are then placed in large vats of artificial pools of salt water. There, after a month or so, their flesh acquires a new and improved flavor. They are then shipped to market.'

MacCallum showed by his expression that he was deeply interested and thanked Dr. Osler for giving him this information. 'It is most remarkable,' he said, 'and all new to me.' None of the others made any comment; so MacCallum had no reason to doubt that this was a real addition to his store of knowledge."

Osler's jokes were played out even on his young resident physicians. Osler once sent John Hewetson,^k a McGill graduate who was on his staff at Johns Hopkins, to look up something in the library at the Philadelphia College of Physicians. William B. Bean²⁴ relates that Osler instructed Hewetson that he needed this information quickly and to travel to Philadelphia and back as soon as possible. He requested Hewetson to "drop in on my old friends, Philip Syng, Physick, and Shippen and give them my love." The young man obviously knew nothing about these long dead historic figures and spent the better part of the day trying to locate them in Philadelphia. Only upon returning to Baltimore did the reason for the failure become apparent.

Osler also directed his mischief against the old. William Bean recounts that when the well-known pediatrician and Jewish scholar, Abraham Jacobi, was 70 years old, Osler attended a commemorative dinner to celebrate his birthday. (Jacobi was born in Germany in 1830. He came to New York

City in 1854 to practice medicine with a special interest in children's diseases. In 1860, he became the first professor of pediatrics in New York City and on the faculty later at the College of Physicians and Surgeons of New York. He was president of the American Pediatric Society, the Association of American Physicians, and other prestigious organizations. He was lauded as the greatest pediatrician of his era.)

At this occasion of the seventieth birthday of America's first pediatrician, Osler²⁵ went off on a acerbic path and went on to another satiric broadside against Dr. Rotch. "There is no single question before this nation today of greater importance than how to return to natural methods in the nurture of infants. The neglect is an old story in Anglo-Saxondom. St Augustine, so Bede tells us, wrote to Pope Gregory¹ complaining that the question of infant feeding was worrying him not a little! I understand that a systematic effort is made to supply every child born in this land its rightful sustenance for one year at least. Under the auspices of the Pediatric Society and the Woman's Christian Temperance Union, a Woman's Infant's Suckling Union is to be established, which will try to make it a criminal offense against the state to bottle-feed any baby, and which will provide in large and well-equipped sucklingries ample sustenance when a mother from any cause is unable to do her duty. Dr. Rotch tells me that in the collective investigation which has been made on the future of bottle-fed babies, it is clearly shown that intellectual obliquity, moral perverseness, and special crankiness of all kinds result directly from the early warp subjected—a deception which extends through many months of the most plastic period of its life. According to these researches, you can tell a bottle-fed man at a glance, or rather at a touch. 'Feel the tip of his nose.' In all sucklings, the physical effects of breast pressure on the nose are not alone evidenced in the manner set forth so graphically by Mr. Shandy,^m but in addition the two cartilages are kept separate and do not join; whereas in bottle-fed babies in whom there is no pressure on the tip of the nose, the cartilages rapidly unite, and in the adult present to the finger a single outline, entirely different from the split bifid condition in the breast-

^j William MacCallum, M.D. was born in 1874. He received his M.D. from Johns Hopkins in 1897 and an LL.D. from Toronto. He was a house medical officer (1897), assistant resident pathologist (1898–1900), and resident pathologist and associate professor (1900–1909) at the Johns Hopkins Hospital and Medical School. He then became professor of pathology at Columbia University (1909–1917). He returned to Baltimore to become chairperson of the Department of Pathology at Johns Hopkins. He was a leader in American pathology in the period following W. H. Welch's tenure and was author of the *Textbook of Pathology* (1916); 7th ed. (1944).

^k John Hewetson, M.D. received his M.D. from McGill University in 1891. He interned at Montreal General Hospital and was an assistant resident on

Osler's medical service at Johns Hopkins Hospital from 1891 to 1894. While studying in Leipzig, Germany during the winter of 1895, he developed acute pulmonary tuberculosis, which tragically caused his young death. Osler wrote a heart rendering memorial in the *Bulletin of the Johns Hopkins Hospital* on December 21, 1910.

¹ Referring to church doctrine that "man shall not carnally accompany with his wife until the child that is born be weaned" (i.e., that a woman should not have sexual intercourse while nursing a baby.)

^m Referring to the 1774 novel, *The Life and Opinions of Tristram Shandy—Gentleman*, dealing with the shape of a nose tip related to the thickness of a nursemaid's breast.

fed child.¹⁸ The collective investigations demonstrate that all silver democrats, many populists, and the cranks of all descriptions have been bottle-fed, and show the characteristic nose tip. Utopian as this scheme may appear, and directly suggested, of course, by Plato,¹⁹ who can question the enormous benefit which would follow the substitution of suckling for Walker-Gordon (developed by Dr. Rotch) laboratories and other devices." So, in addition to the biting satire against Rotch, the whole segment of the speech was also a clear double entendre for those of the audience acquainted with the classics.

In contrast to Rotch, Dr. Jacobi must have forgiven his younger colleague for later, in October 1904, Abraham Jacobi was again visiting the Oslers in Baltimore to give a speech to the medical society. This time, Osler handed a reporter background material about the distinguished visiting pediatrician from New York City. Osler gave the reporter a blurred photograph of an Irishman, John L. Sullivan (the boxer), and told the young reporter that this was Jacobi. Yet to other reporters, Jacobi (who was in actuality a small hunchbacked man) was described by Osler as a very athletic high jumper and pole vaulter, "a star performer for the New York Athletic Club." All these comments made the papers, pictures and all, and may have ended the professional careers of the young reporters who should have known better as they should have seen previous pictures of Sullivan. The newspapers later took revenge on Osler, but that is another story.

Osler certainly must have suspected that some of his jokes could have hurt. He said,⁵ "I have made mistakes, but they have been mistakes of the head, not of the heart. I can truly say, and I take upon myself to witness, that in my sojourn among you—I have loved no darkness, sophisticated no truth, nursed no delusion, allowed no fear."

Yet, Osler had a strong hold on people, especially the very young. He succeeded with people as none of his contemporaries had before. Ralph Waldo Emerson (1803-1882), American poet, essayist and philosopher, said it best when he wrote: "To laugh often and love much; to win the respect of intelligent persons and the affection of children; to earn the approbation of honest citizens and endure the betrayal of false friends; to appreciate beauty; to find the best in others; to give of one's self; to leave the world a bit better, whether by a healthy child, a garden patch, or a redeemed social condition; to have played and laughed with enthusiasm and sung with

exultation; to know even one life has breathed easier because you have lived—this is to have succeeded."

Perhaps this accounted for Osler's strong hold on people. His keen sympathy and affection for young people enabled him to enter their joys and sorrows and to keep young. The mischief and even the cruelty of his practical jokes were just as much a part of, and possibly added to, his charisma and radiant personality, which captivated people and made them feel special. Perhaps these so-called practical jokes were the vehicles to accomplish this.

Perhaps Gulland of Edinburgh captured his true spirit in these words, "It was his personality and his personal radiation which gave him the immense power for good which he possessed."

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¹⁸ Osler also pokes fun at the phallus-y (forgive my pun) that the size of the nose is proportional to the size of the penis, which was seriously referred to by Johns Hopkins ENT Professor John Noland Mackenzie in an article published in the *Johns Hopkins Hospital Bulletin*, in 1898 entitled, "The physiological and pathological relations between the nose and the sexual apparatus of man." He wrote that, "The nose, for example, that was large and firm was looked on as an index of a penis acceptable to women."

Mackenzie was the sexist ENT professor referred to by Dorothy Reed,²⁸ the 1898 Hopkins medical student who reported on a lecture by a nose and throat specialist: "He dragged in the dirtiest stories I ever heard . . . when he wouldn't say it in English, he quoted Latin."²⁹ "For the greater part of his lewd lecture, Mackenzie compared the tissue of the

nasal passages to the corpus spongiosa of the penis, as roars of laughter filled the room. The women sat through the lecture maintaining their composure as best they could, rushing out when it was over; 'I cried all the way home—hysterically—Margaret [Long] swore.'³⁰ when Osler returned, she reported to him his substitute's accusations. Osler, although no feminist himself, had by this time noted Reed's talent, and he harshly censored the man."²⁹

¹⁹ In book V of Plato's *The Republic*, Socrates recommends selective breeding to improve the human race and segregating future leaders under the care of separate wet nurses.

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Notes adapted From Howard RP. *The Chief: Dr. William Osler*. Canton, MA: Science History Publications. 1983 ■

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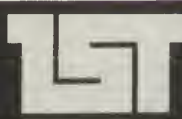
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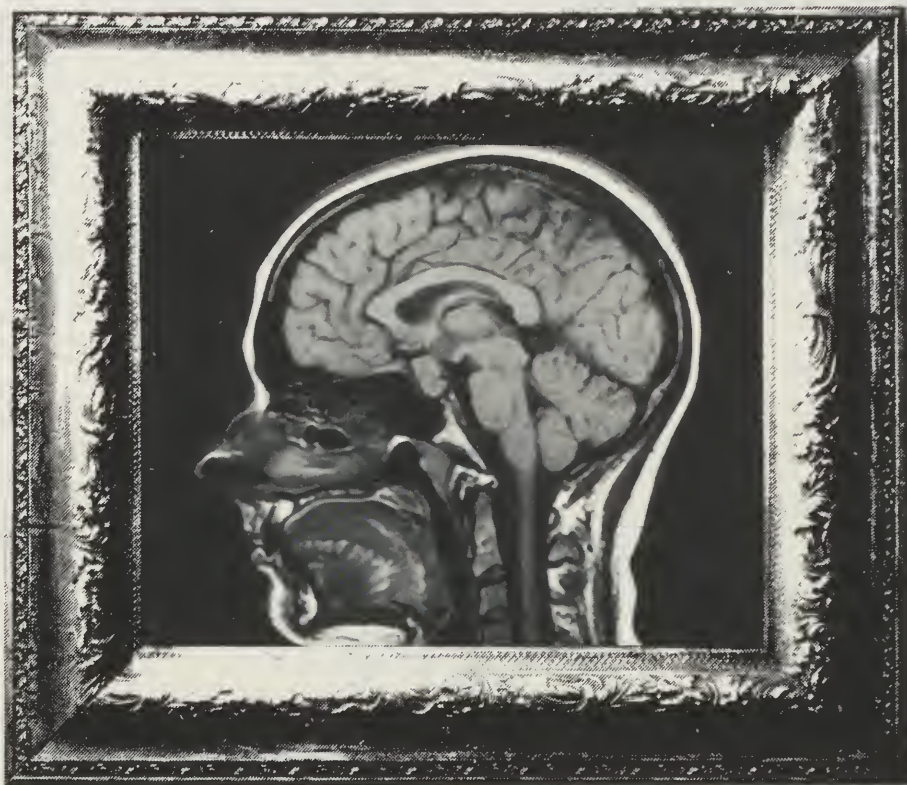
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Johns Hopkins

BELUR S. BHAGAVAN, M.D., Editor
ROBERT E. WENK, M.D., Associate Editor

A 19-month-old child with cough, stridor, fever, respiratory distress, and seizures.

Participants: Frank A. Oski, M.D.; Grover M.
Hutchins, M.D.; George Taylor, M.D.;
and G. Scott Hall, M.D.

PRESENTATION OF CASE

This 19-month-old male child presented with respiratory distress and was in an unresponsive state. The patient had an approximately four-day history of non-productive cough. One day prior to admission, he suffered stridulous breathing and was treated at home with a humidifier. On the day of admission, the child's mother found him unresponsive, with marked respiratory distress. He was taken to a local hospital where physical examination demonstrated fever (42.6°C), diaphoresis, respiratory depression, and a normal epiglottis. He was intubated, placed on mechanical ventilation, and received epinephrine, Solumedrol (methylprednisolone sodium succinate), and Alupent (metaproterenol). Ventilation was difficult because of poor pulmonary compliance. Lab values included WBC (white blood count), 17,200/mm³ (59% polymorphonuclear leukocytes, 20% bands, 17% lymphocytes, 4% monocytes); Hgb (hemoglobin), 12.1 gm/dl; Hct (hematocrit), 36.1%; platelets, 258,000/mm³; Na (sodium), 146 mmol/L; K (potassium), 5.2 mmol/L; Cl (chlorine), 104 mmol/L; CO₂ (carbon dioxide),

21 mmol/L; serum urea nitrogen, 16 mg/dl; creatinine, 0.4 mg/dl; and glucose, 352 mg/dl. Blood cultures were drawn and cefuroxime was administered. He subsequently had generalized seizures treated successfully with diazepam, Dilantin (phenytoin), and phenobarbital. He was transferred to the Johns Hopkins Hospital Pediatric Intensive Care Unit.

The patient was the product of a 34-week gestation. He had had a three-week special care nursery course with initial poor feeding. All immunizations were up-to-date. Medical history was otherwise negative.

Family history was noncontributory.

Medications included a proprietary cough medicine containing pseudoephedrine and chlorpheniramine.

On physical examination, the temperature was 40.8°C, blood pressure was 60 mmHg systolic, heart rate was 220/min, and respiration rate was 16 on ventilator.

General findings. He appeared sedated. Head, eyes, ears, nose, throat: Atraumatic. Pupils: Right 3.0 mm, Left 2.5 mm, reactive bilaterally, discs sharp, no hemorrhages. Ears: Tympanic membranes bright red, mobile. Endotracheal tube in place, normal epiglottis. Neck: Supple. Chest: Left, clear; right, breath sounds slightly decreased. Heart: Tachycardia, otherwise normal. Abdomen: Soft, no masses, no hepatosplenomegaly. Genitalia: Normal. Extremities: No edema, no cyanosis, no clubbing. Skin: No rashes, hemorrhages, or insect bites. Neurologic examination: Sedated, pupils reactive, negative doll's eyes, negative corneals, positive cough and gag reflex, disconjugate gaze.

Lab values. Na, 153 mmol/L; K, 3.8 mmol/L; Cl, 114 mmol/L; CO₂, 13 mmol/L; serum urea nitrogen, 37 mg/dl; creatinine, 1.4 mg/dl; glucose, 129 mg/dl; total Ca (calcium), 7.2 mg/dl; inorganic PO₄ (phosphate), 5.7 mg/dl; total Mg (magnesium), 1.9 mg/dl; NH₃ (ammonia), 51 mmol/L; alanine aminotransferase, 183 U/L; aspartate aminotransferase, 413 U/L; total alkaline phosphatase, 291 U/L; creatine kinase, 7,625 U/L; creatine kinase-MB 80 U/L; Hct, 36.1%; Hgb, 11.5 gm/dl; WBC, 6,200/mm³; polycytes, 75%; lymphocytes, 24%; monocytes, 1%; platelets, 92,000/mm³; prothrombin time (PT), 1.5 x nl; activated partial thromboplastin time (PTT) 2.2 x nl; and toxicology screen—acetone present. Cerebrospinal fluid: glucose, 96 mg/dl; total protein, 32 mg/dl; clear, leukocytes, 6/mm³ (polymorphonuclear leukocytes, 17%; monocytes, 83%; erythrocytes, 0%). Latex agglutination negative (for *Haemophilus influenza*, *Streptococcus pneumoniae*, group B *Streptococcus* and *Neisseria men-*

From Johns Hopkins School of Medicine where Dr. Oski is Givens professor of pediatrics in the Department of Pediatrics; Dr. Hutchins is professor of pathology in the Department of Pathology; Dr. Taylor is associate professor of radiology and associate professor of pediatrics in the Department of Radiology; and Dr. Hall is postdoctoral fellow in pathology.

Dr. Bhagavan is associate professor of pathology, Johns Hopkins School of Medicine, and pathologist-in-chief, Sinai Hospital. Dr. Wenk is assistant professor of pathology, Johns Hopkins School of Medicine, and head of clinical pathology, Sinai Hospital.

ingitidis). Head computed tomography (CT) scan normal. Chest radiograph: Right upper lobe alveolar infiltrate. Endotracheal tube aspirate—gram positive cocci. Culture: *Staphylococcus aureus*. Urine culture: *Staphylococcus aureus*. Bacterial, viral, fungal cultures of cerebral spinal fluid (CSF), blood, urine and sputum otherwise negative.

Hospital course. Shortly after the patient's arrival in the pediatric intensive care unit, he suffered progressive bradycardia and hypotension that necessitated full cardiopulmonary resuscitation. Sinus rhythm and hemodynamic stability were restored. He remained febrile and was maintained on vasopressors and administered broad spectrum antibiotics, including chloramphenicol.

During the next 18 hours, the patient's neurologic status deteriorated. Repeat examination demonstrated fixed and dilated pupils, negative doll's eyes, areflexia, and negative cough and gag reflexes. Massive cerebral edema with obliteration of subarachnoid spaces and basal cisterns was seen on repeat head CT scan. Thirty-six hours after his initial presentation, examination demonstrated brain death. Permission for autopsy was granted.

DISCUSSION

Dr. Frank A. Oski: I would like to begin this case discussion by pointing out that a 19-month-old infant presented with a relatively common symptom, an inspiratory stridor. This case ended, in my opinion, with an uncommon and tragic outcome.

Let's talk about the presentation of this child. We are told the child had been well until about four days before he was first hospitalized, and he apparently had a cold and a nonproductive cough. The term nonproductive is meaningless in a 19-month-old infant, because no 19-month-old infant produces sputum. One doesn't begin to produce sputum in association with pulmonary disease before 4 or 5 years of age.

We are told that the boy had symptoms of a respiratory illness. He had a nonproductive cough and then he developed stridor, presumably inspiratory stridor. This has certain meanings to pediatricians, and the child's illness falls into a group of disorders we call croup syndrome.

The term croup describes a certain musical quality to inspirations. Croup syndromes are all characterized by some form of obstruction in the airway, and the croup we are talking about may be caused by some problem above the glottis, at the level of the glottis, or below the glottis. One must consider the different syndromes and the causes because they have different forms of treatment and different prognoses.

Croup syndromes are characterized primarily by the sound of the inspiration. A barking cough often

accompanies the inspiratory stridor. Depending on the location of the disease in the respiratory tree, the child may have difficulty swallowing, drooling, handling bronchial secretions, or handling the material produced within the lungs themselves.

Let me contrast these conditions and then put this case in context.

The one disorder that we are most concerned about is acute inflammation of the epiglottitis. Affected children characteristically are well initially, but over the course of 12 to 24 hours they develop extreme toxicity and high fever (usually temperatures in the range of 39 to 40 degrees centigrade), and, in association with their inspiratory stridor, they have a bulbous, swollen epiglottis. Usually the cause of the illness is *Haemophilus influenzae* infection of the respiratory tract with localization to the epiglottis. Children will appear anxious and frightened looking, and are often drooling. They cannot swallow their secretions because of the obstruction produced by the enlarged epiglottis. They often sit forward in their chair, trying to maintain their airway, because if they sit back or lay back, the epiglottis may flop back and obstruct the airway. These children have to be examined very carefully by someone who is prepared to intervene if, on physical examination, there is, indeed, a large, bulbous epiglottis. Often, if the child is not too sick, one can get lateral views of the neck that will assist in determining if the child does, in fact, have an enlarged epiglottis. These children are then intubated with a prosthetic oral airway or a nasal-oral airway and treated with appropriate antibiotics; within 24 to 48 hours, the condition resolves. Children are then extubated and do well. The condition is, however, an emergency that has to be treated with alacrity. There are noninfectious causes of epiglottic swelling as a result of allergic reactions, angioneurotic edema, or trauma, but the history would not involve a child with a cold and a very high fever.

Another condition that often produces some impingement of the airway is acute infectious laryngitis. I suppose most people in this room have experienced laryngitis. Children with it typically present with hoarseness, but may be afebrile. Laryngitis usually does not produce obstruction of the airway to the point of respiratory embarrassment.

The next disease on the list is properly called acute laryngotracheitis, but in common parlance it is also called croup. When a pediatrician talks about croup, he or she is usually referring to an entity that is caused primarily by viruses. The common viruses that cause infection in the tracheobronchial tree and cause croup are parainfluenzae, respiratory syncytial, and adenoviruses. Rarely is croup caused by bacteria. Of the bacterial species that can cause the signs of croup, the most common is *mycoplasma*.

With croup, children are not very toxic. That is, they do not have a high fever, but they have great dif-

difficulty in breathing. They produce inspiratory noises and often display nasal flaring and rib retractions because of edema and secretions of the subglottic area. Subglottic edema narrows the airway and produces difficulty in inspiring air. These patients are managed in a slightly different fashion because the etiology is not usually bacterial. These patients are given direct nebulization, usually in the form of racemic epinephrine, to induce some vasoconstriction and produce some relief of obstruction. They are often placed in a mist tent to facilitate inspiration and respiration. These children are also treated with large doses of steroids in order to provide relief from the local edema, which then allows them to improve respiration. Patients with croup of this variety are often sick for three to five days. The disease frequently worsens late in the day in children who have been suffering from symptoms of a mild cold, perhaps for a day or two. Subsequently, there is a progressively developing barking cough and difficulty with inspiration.

In the old days (when I say old days, I am talking a hundred years ago), most croup was the consequence of diphtheria. Diphtheritic children got sick and became sicker over the course of two or three days. They developed an exudative membrane, an adhesive membrane, often visible in the nasopharynx, certainly present on the larynx below the level of the vocal cords. Diphtheria caused a desperate situation, producing severe respiratory embarrassment. Often, children could only be salvaged if prompt tracheotomy was done. But today, obviously in this part of the world, we rarely see diphtheria, although there are outbreaks of diphtheria recorded around the world in unimmunized children.

The next condition that causes croup-like syndrome is bacterial tracheitis, which produces a very high fever, as does acute epiglottitis. Tracheitis is not caused by viruses, but is a bacterial infection that is rarely a cause of respiratory stridor.

To put the nosology in context, let me cite a study of 332 children admitted to the Winnipeg Children's Hospital over a four-year period with the clinical picture of inspiratory stridor.¹ Of those children, 28 were recognized to have epiglottitis (8%), and they were treated as I described with antibiotics and by inserting an oral airway. All of those children survived. The remaining 304 children (91%) were considered to have non-epiglottic croup; and of that group, 23 children were in such a desperate state that they were admitted to the hospital's pediatric intensive care unit. Of that group of 23 patients, seven ultimately were found to have bacterial tracheitis. These children were separated out from the rest because of two primary findings. First, these children were desperately ill with high fevers. Second, airway examination was characteristic.

The child presented in today's discussion had a temperature of 42°C before his transfer to Johns Hopkins Hospital. This is not an uncommon fever in

a child with tracheitis, but the diagnosis was established by examination of the airway; one sees a normal epiglottis in bacterial tracheitis. The child presented here had a normal epiglottis. One also finds purulent secretions below the level of the vocal cords in bacterial tracheitis. The cords are not usually involved, but in necrotizing tracheitis, it is commonplace. Affected children have extensive, tenacious secretions that block the airways and make it very difficult for inspiration or expiration to occur.

Of the group of seven children in the Winnipeg study with tracheitis (2% of the children presenting with inspiratory stridor), two died because of obstruction of the airway by pseudomembranous material produced in the lung.

I will compare two other studies that describe patients with bacterial tracheitis in recent years. The entity is being rediscovered, although presumably it has existed for many years. One study was of eight children, and another was of seven children.^{2,3} The age of affected patients ranged from one month to six years in both studies. The mean age of the children was about 22 months, which is very close to the age of the child described here today. The mean temperature on admission was 39.1 degrees centigrade in one study and 39.2 degrees in the second. (It is not uncommon for these children to have temperatures of 103, 104, or 105 degrees Fahrenheit.) The average white counts were elevated in both studies with 17,000/mm³ in one and 14,000/mm³ in the other. These are not too different from the white count described in our patient. Pneumonia was seen on chest x-ray in seven of eight cases in one study and all seven in the other. Again, our patient had some pulmonary infiltrate at the time he was initially x-rayed. We don't know the rate of progress of the pneumonia, but having pneumonia along with the tracheitis is not an uncommon event.

In one study, two of the eight children died; seven died in the second study. Currently, when physicians are confronted with acute bacterial tracheitis, they should start patients on appropriate antibiotics, but also consider performing a tracheotomy. An oral airway may be unreliable because the pulmonary toilet is so difficult in this situation.

The vast majority of bacterial tracheitis patients have *Staphylococcus* as the etiologic agent. We are told that *Staphylococcus* was cultured from tracheal secretions in this patient, and *Staphylococcus* was even isolated from the urine, suggesting he had systemic illness and not simply focal disease in his lungs. I suspect that the patient died as a result of obstruction of his airway, producing intermittent and then persistent hypoxic encephalopathy, resulting ultimately in brain swelling and death.

I suspect also that at autopsy, we will find a necrotizing pneumonia, a necrotizing tracheitis, and thick, tenacious secretions. I think this child had an

uncommon disease—bacterial tracheitis—with a sad outcome.

It would be interesting to examine his tracheo-bronchial tree on x-ray to see if there is any evidence indicating the site of the respiratory problem.

Dr. George Taylor: A chest radiograph obtained at the outside hospital showed an ill-defined area of right upper lobe opacification. The airway was difficult to evaluate due to the presence of an endotracheal tube. A second chest radiograph (Figure 1) obtained later the same day showed progression of the right upper lobe consolidation. At admission to this hospital, a cranial CT was obtained, which was interpreted as normal. A repeat CT the next day showed diffuse hypodensity of the cerebrum, with obliteration of the basal cisterns and lateral ventricles strongly suggestive of cerebral edema and diffuse ischemic injury. A pertechnetate brain blood flow scan obtained the same day showed absent intracranial flow (Figure 2).

Dr. Oski's diagnosis.

Staphylococcal tracheitis with
mechanical obstruction of airway

Dr. Grover M. Hutchins: At the time of autopsy, the organs in this child showed evidence of the severe hypotension that had been present during the latter phases of his life. In the kidney we found extensive dilatation of the tubules and necrosis of the tubular epithelium, typical of acute renal failure. In the liver,



Figure 1. Second chest radiograph showing opacity in right upper lobe.

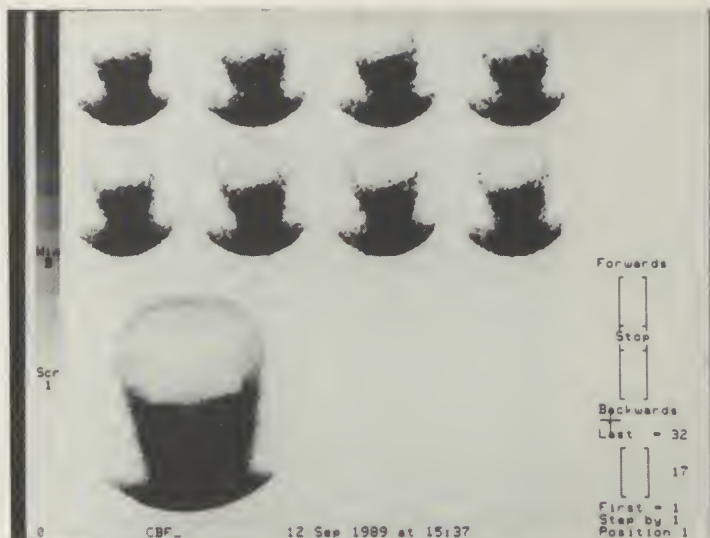


Figure 2. Pertechnetate cerebral scan showing absent blood flow.

there were fatty changes indicative of sublethal ischemic injury and early necrosis of the central lobular areas. In addition, there were small areas of loss of hepatocytes with a mild inflammatory reaction that is suggestive of an injury from some agents within the circulation (Figure 3). The brain was markedly edematous. There were small capillary hemorrhages and alterations within the vascular beds, suggesting injury to the endothelial cells of these regions.

The thymus, which is a good indicator of the duration and severity of infectious processes, showed little change in this case, demonstrating the rapidity of the patient's terminal course. In the other lymphoid tissues, however, there was a striking reaction within the germinal centers, as seen in the spleen (Figure 4). Findings are typical of those situations in which there is a marked antigenic stimulus to the lymphoid tissues. These changes were found in lymphoid tissues throughout the body. The larynx and the upper glottis were perfectly normal, but within the

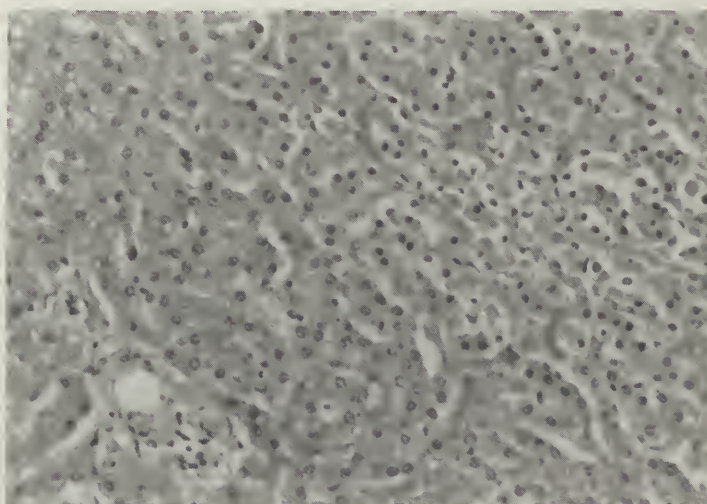


Figure 3. Liver with a portal triad in the lower left and a focus of early hepatocyte necrosis in the upper right. This pattern of necrosis may be found with sepsis or toxic injury.



Figure 4. Spleen showing marked germinal center hyperplasia. This reaction is found when there is a response to an antigenic stimulus in the circulation.

trachea, as has been predicted, there was significant alteration. There was loss of epithelium and a good deal of inflammatory cell infiltration. It is possible that some of this is related to the intubation, but in other regions, there is a very striking pseudomembranous inflammatory reaction involving the inner layers of the tracheal and bronchial walls, and a purulent exudate on the surface of the tracheobronchial tree (Figures 5 and 6). *Staphylococcus* was grown from

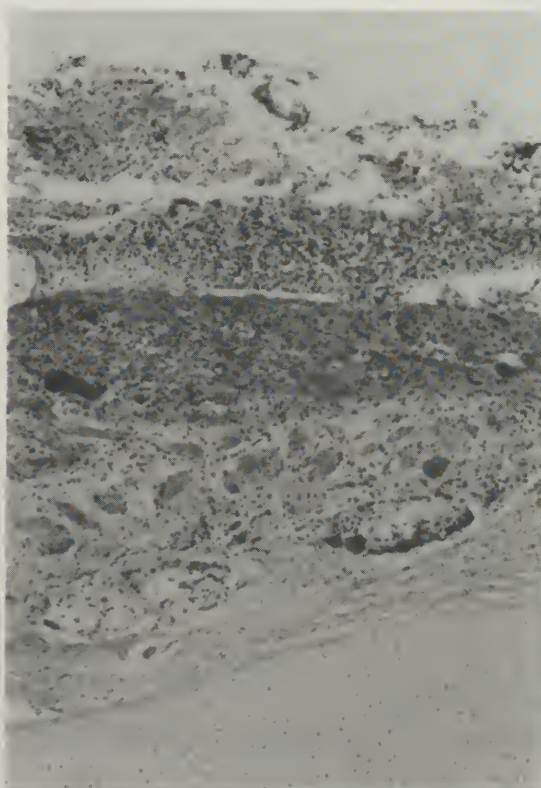


Figure 5. Pseudomembranous inflammation in the trachea. A layer of mucopurulent material and necrotic respiratory epithelium covers the tracheal surface.

this material at the time of autopsy—a light growth—but organisms were extremely difficult to identify with special stains. I think this probably attests to the effectiveness of the antibiotic therapy that the patient was given. Further down in the tracheobronchial tree, there was extensive bronchitis (Figure 7). Inflammatory infiltrates filled many of the airspaces without much extension into the areas of parenchyma surrounding them. There are a few focal hemorrhages here and there, but most of the parenchyma looked normal. More severe disease, as you have seen radiographically, was encountered in the right upper lobe. Here there was an extension of the acute bronchitis into the pulmonary parenchyma with early bronchopneumonia and some associated hemorrhages. All in all, there was a fairly early stage and mild to moderately severe acute tracheobronchitis and bronchopneumonia. We were unable to demonstrate any evidence for direct mechanical obstruction to the airways.

There was one particularly striking feature in the adrenals. The zona glomerulosa and the zona reticularis were quite well preserved, but the zona fasciculata was selectively destroyed (Figure 8) by very extensive necrosis of the epithelial cells. This child had a fulminant illness with fever, hypotension, and, as demonstrated at autopsy, the tracheitis that we know to have been caused by a staphylococcal infection. It was difficult for us, in the context of the autopsy findings, to accept that this tracheitis entirely accounted for the death of this child. We think that there may be another component of the illness and suggest that the child may have had the so-called toxic shock syndrome. From epidemiologic studies, it has been recommended that toxic shock syndrome be defined on the basis of the presence of four major criteria, which should all be present, and on three or four minor criteria that should be identified as well. These criteria are listed in the Table.

Fever and hypotension were very prominent parts of the presentation in this patient. The desquamation of skin that is observed in toxic shock syndrome only evolves after a period of time, usually a couple of weeks or so. This case is atypical for toxic shock syn-

Table. Toxic shock syndrome

Major criteria	Minor criteria
Fever	Diarrhea or vomiting
Rash	Myalgia
Hypotension	Mucous membrane hyperemia
Desquamation	Renal failure
	Hepatic dysfunction
	Low platelets
	Disorientation
No infection other than <i>Staphylococcus aureus</i>	



Figure 6. Another area of the tracheitis (at high magnification) with less injury to the respiratory epithelium. Staphylococci were very difficult to demonstrate in the exudate.

drome in that there was no rash either clinically or at the time of autopsy; however, several of the minor criteria were present. There was evidence for injury to the skeletal muscle, as shown by the serum enzymes. There was renal failure, hepatic dysfunction, reduced platelets, and, of course, central nervous system problems. Neither clinically nor at autopsy were

seen in only about 50% of the cases that are nonmenstrually related. It has been suggested that some of the other staphylococcal enterotoxins may account for the clinical presentation. It has also been suggested that the clinical manifestations may be produced as a consequence of induction of tumor necrosis factor by the toxin.⁷

A recent paper has called attention to the fact that there may be cases in which there is an atypical presentation.⁸ Much more needs to be known about this condition before the full range of its presentation, causes, and pathophysiology is understood.

I was particularly interested in the adrenal changes in this child, the disruption of the majority of the zona fasciculata. These changes are very reminiscent of a paper written many years ago by Dr. Arnold R. Rich of our department in which he described an essentially identical site of adrenocortical injury associated with several different organisms, and also called attention to its possible relationship to the circulatory collapse.⁹ There have been relatively few detailed autopsy studies of patients with toxic shock syndrome, and it may be that this phenomenon of injury to the zona fasciculata of the adrenal may

also be important in the evolution of the clinical process in these cases.

In summary, this patient certainly had a staphylococcal tracheitis. We are a little perplexed to account for death and the overall severe collapse in this patient on the basis of the tracheitis alone, and believe that his clinical condition may perhaps be explained as an atypical form of toxic shock syndrome. Dr. Oski, do you have any comments?

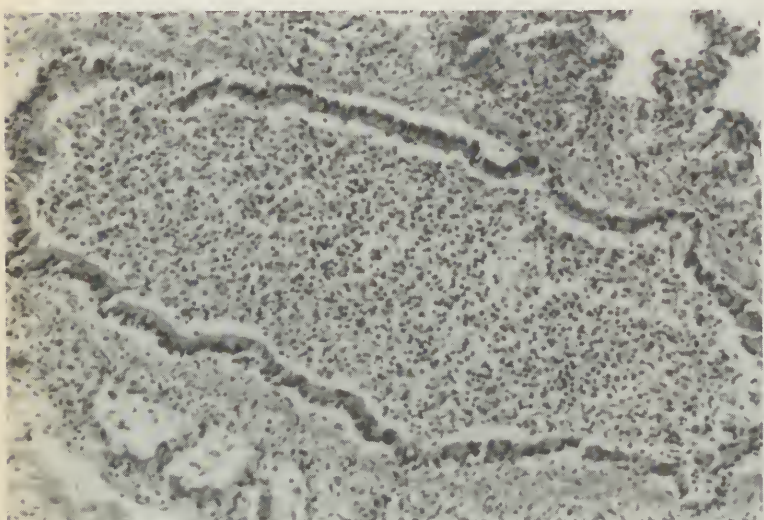


Figure 7. Intrapulmonary bronchus with acute bronchitis. In some areas, the inflammatory process extended into the parenchyma as bronchopneumonia.

we able to identify any evidence of infection other than by *Staphylococcus aureus*, which is another defining feature of toxic shock syndrome.

The history of this particular entity is a relatively short one. The naming of the condition and the description of a number of pediatric cases occurred in 1978 by Todd and his associates,⁴ although in retrospect, there had been a number of cases described perhaps even 50 years earlier which probably fit into

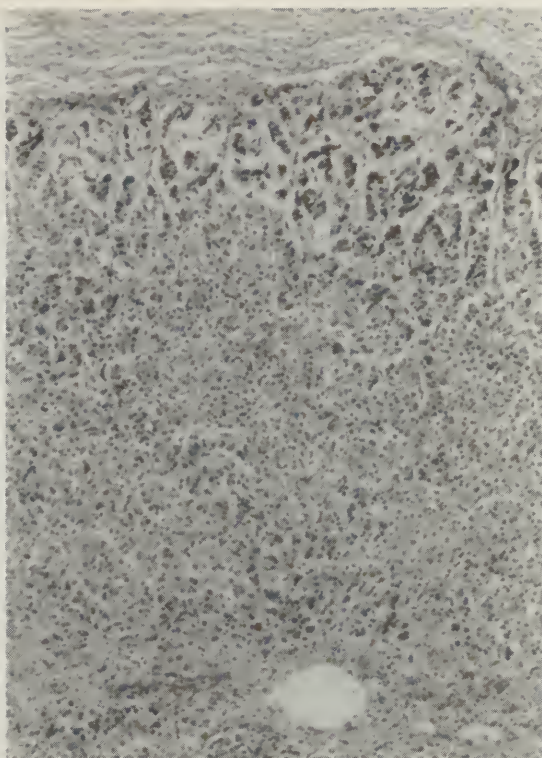


Figure 8. The zona glomerulosa (top) and zona reticularis (bottom) of the adrenal are intact but the zona fasciculata (middle) has undergone severe necrosis.

Dr. Oski: I find this fascinating. As I mentioned before, many patients with bacterial tracheitis do die. Conceivably, this mechanism may be operating in these patients as well. I am totally unfamiliar with toxic shock syndrome due to staphylococcus that is not associated with a rash. That is one of the real constants, so I would never have thought about it and probably will miss the next case, too.

Dr. Hutchins: One article to which I referred did in fact call attention to this particular phenomenon, namely that the rash may be somewhat delayed in appearance in these cases.⁸ One of the patients that they described as having an atypical toxic shock syndrome, did have an initial presentation without the rash; but it appeared subsequently. The other case was very delayed in developing desquamation of the skin, which is another typical feature of the condition. Let me emphasize that we do not feel certain about this diagnosis, but felt that it was a reasonable interpretation of this case in view of our lack of conviction about mechanical obstruction as the cause of the patient's illness.

Are there any questions from the audience or comments?

A voice: Is there a pharmacological way to demonstrate the presence of toxic shock syndrome?

Dr. Hutchins: The TSST1 has been demonstrated in the majority, if not all, of the cases of the

tampon-associated toxic shock syndrome. The non-menstrual cases of toxic shock syndrome have had TSST1 in about 50% of the cases, and, as I mentioned, the assumption is that in the other 50%, where it has not been demonstrated, the clinical syndrome may be related to one of the other staphylococcal enterotoxins. There are six or seven of these that may behave in a somewhat similar manner. It is conceivable that the absence of a rash in this case could be explained by the presence of one of the other toxins producing some of the manifestations and tissue injury, rather than TSST1.

Dr. Oski: Dr. Hutchins, do we know what the bug was in Dr. Rich's case in 1944?

Dr. Hutchins: He did not detail all of the organisms in the cases that he reviewed, but he had seen zona fasciculata lesions in the adrenal gland with streptococci and diphtheria. He did not specifically mention the *Staphylococcus*.

Dr. Oski: It could be a response to some kind of fulminating bacterial infection, not particularly staphylococci.

Dr. Hutchins: Yes, absolutely.

A question I have for you about this case is this: Would you think that acute destruction of the zona fasciculata could account for hypotension in this patient?

Dr. Oski: I think it is possible. I see that at one time he received some kind of steroid treatment early on, I think at the initial hospital. I have reason to believe that the tube that was taken out at one time was obstructed. I still think he had hypoxia too.

Dr. Hutchins' Diagnosis

Staphylococcal tracheobronchitis and bronchopneumonia with probable toxic shock syndrome.

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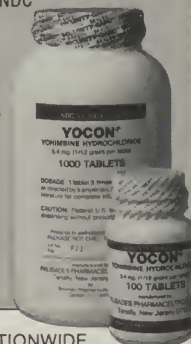
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Imaging Case of the Month

A newborn had tachypnea, respiratory distress and abnormal location of heart sounds (on the right). There was no evidence of hypothermia or temperature instability. Apgar scores were 6 and 6. Labor and delivery were uncomplicated. Maternal and infant white blood count were normal. **Figure 1** is a chest radiograph of the infant. **Figure 2** represents a different form of the same condition.



Figure 1.



Figure 2.

Congenital cystic adenomatoid malformation of the lung, type III

Figure 1. Congenital cystic adenomatoid malformation of the lung, type III.

Figure 2. Congenital cystic adenomatoid malformation of the lung, type I.

Congenital cystic adenomatoid malformation of the lung (CCAM) represents a hamartomatous lesion usually involving one lung. It is characterized by multiple cysts of varying size. There is also adenomatous hyperplasia evidenced by an increase in terminal bronchiolar structures, and the affected lobe is increased in volume and weight. Some bronchial communication is usually present.

Radiographically, the findings are quite variable, depending on whether the cystic component or the adenomatous hyperplasia component predominates. CCAM has been commonly classified as follows: type I, the most common, consists of multiple, varying sized cysts that are frequently large (**Figure 2**); type II, representing about 40 percent of cases, consists of multiple, small, thin-walled, even-sized cysts; and type III, the rarest, is composed of microscopic cysts that can appear as a solid process or as a pneumonic consolidation (**Figure 1**).

Relatively few cases have been described antenatally. Prenatal sonographic appearance has ranged from a multicystic mass (types I and II) to a solid lesion with mass effect (type III). Fetal hydrops and polyhydramnios can also be seen. Anasarca is probably due to venous and cardiac compression by the mass lesion. Additional congenital abnormalities can coexist.

Diagnosis of CCAM may not be obvious immediately because in some cases the cysts become large and uniform

and mimic the air-filled loops of congenital diaphragmatic hernia. However, the abdomen gas pattern and abdomen physical examination in CCAM are normal. In a few cases, the cysts may be extremely large and, at first, suggest congenital lobar emphysema or pneumothorax. In type III, neonatal pneumonia, asymmetric retained fetal lung fluid, or mediastinal mass may be the initial diagnosis, but the absence of laboratory and clinical signs and symptoms of sepsis or an unchanging chest radiograph should lead to the proper diagnosis. Occasionally, computed tomography of the thorax may be necessary.

Excision of the cyst may be required as an emergency procedure when there is respiratory distress in the neonatal period. Contralateral pulmonary hypoplasia can coexist if compression of the uninvolved lung is severe.

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EDGAR C. FEARNOW, M.D.
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A Clinical Moment with...Diabetes

Management of type I diabetes for children in school

Doctor, my 8-year-old daughter has had diabetes for two months. She will be returning to school in the fall. I am concerned because there is not a school nurse available on a full-time basis. How can I best prepare the school to handle diabetes problems that may arise?

Many parents of children with diabetes worry that no one will be available at the school who is capable of handling a diabetes-related emergency. The first step is to meet with school personnel to discuss your concerns. You should meet with the school nurse or health aide, all teachers with which your daughter has contact, including the gym teacher, as well as the school bus driver.

The most common diabetes-related medical emergency encountered in the school is hypoglycemia (low blood sugar or insulin reaction). It requires prompt recognition and treatment. School personnel should know the warning signs—shakiness, paleness, sweating, hunger, drowsiness or sleepiness, headache, confusion, mood swings, or inappropriate behavior. Provide the school with the necessary supplies for treatment—fruit juice, honey or sugar, or commercially prepared products such as Glutose, Insta-glucose, BD glucose tablets or Cake Mate icing. School personnel should be told that if your daughter does not feel better in 10 minutes, the treatment needs to be repeated. If a meal or snack is not scheduled within the next 15 minutes, school staff should be instructed to follow the initial treatment with a protein and carbohydrate source, such as milk, cheese, or peanut butter and crackers. Teachers should also be informed that if your child has a severe reaction that causes loss of consciousness or seizures or is unable to eat or drink, Glucagon (a prescription medication given by injection) may be administered by the school nurse. School personnel

should call 911 and you if such an emergency occurs. Let school staff know that a child with diabetes should never be left alone during an insulin reaction, nor should a child be sent to the nurse's office alone during a reaction; the child may become confused and the reaction could worsen.

Fortunately, there are several resources available to help school personnel understand how to care for a student with diabetes. In May 1991, *Guidelines for the Child with Diabetes in the Classroom* was approved by the Maryland State Department of Education, the Maryland Department of Health and Mental Hygiene, and the American Diabetes Association (ADA), Maryland Affiliate. These guidelines are available in all Maryland public schools from kindergarten through high school. A copy may be obtained by calling the ADA, Maryland Affiliate at 410-486-5515. The ADA also provides a slide/script program to show to school personnel. Other literature available from the ADA includes *A Word to Teachers and Child-Care Providers* and *Caring for Children with Diabetes*. The Juvenile Diabetes Foundation provides a brochure called *A Child with Diabetes is in Your Care*.

Although the child with diabetes has special needs, it is important that the child participate fully in all school activities and be treated in a similar manner as the other children in the class.

LORETTA CLARK, R.N., C.D.E. Ms. Clark is a diabetes nurse educator at the Johns Hopkins Children's Center.

LESLIE PLOTNICK, M.D. Dr. Plotnick is an associate professor of pediatrics, Division of Pediatric Endocrinology, Johns Hopkins Hospital.

JAMES H. MERSEY, M.D.
Department editor ■

WORD ROUNDS

Political patois

The Common and Hoary Redpoll are two species belonging to the Fringillidae family of birds—small finches with distinctive red caps, found among the grassy weeds of the arctic tundra. (**Poll** from the Dutch word *pol* ‘top of the head’.)

Tadpoles are also named for their crowns—*tad* ‘toad’ + *poll* ‘head’. They are **toadheads** as anyone can plainly see. Sometimes they are called **polliwogs**: *poll* ‘head’ + *wigelen*, middle English for ‘wiggle’—that is, **wiggle heads**. Again, an apt description.

Human polls are **head counts**. These always precede, and sometimes follow, elections. (Latin *electus* from *eligere* ‘to pick or choose’.)

In ancient Rome, those who aspired to public office dressed in long white robes to signify their purity. They were known as *candidatus* ‘clothed in white’—the source of our own **candidates** (which makes them something of an oxymoron). We find the root *cand*—indicating white, pure, or bright—in several words: **incandescent**, **candelabrum** (something which holds **candles**), **candid**, and **candor**. **Candidiasis** causes white exudates on oral and vaginal mucous membranes. It originates from *Candida albicans*, a redundancy if there ever was one. **Candida**, from the Latin *candidus* ‘gleaming white’, and **albicans** from *albicare* ‘to make white’. (The earlier name for this affliction was **moniliasis**. Latin *monile* ‘a necklace’ from its microscopic resemblance to a string of beads.)

Democrats come from Greek *demos* ‘the people’ + *kratein* ‘to

rule’, that is, rule by the people. **Demographics** are statistical analyses of people; **demagogues** (Greek *agōgos* ‘leader’) were originally advocates for the common people, the earlier sense having become quite transformed and perverted; and **epidemics** are diseases that spread upon (*epi*) the population.

Republicans, on the other hand, come from Latin *res* ‘things’ and *publicus* ‘public’ (e.g., having to do with public matters).

An **aristocracy** is rule (*kratein*) by the ‘best’ (Greek *aristos*). A **theocracy** is rule by a god (Greek *theos*), or at least by a group who claim divine authority. A **plutocracy** is government by the wealthy (Greek *ploutos*). Our government, of course, is clearly a **bureaucracy** (French *bureau* ‘agency’). The literal meaning of **bureau** is ‘writing table’. It derives from the custom of covering desks with a table cloth made of a coarse material known as a **burel**, which, in turn, emanates from the Latin *burra* ‘wool’. Eventually, the cover itself came to refer to the entire desk, and still later, to an office filled with such desks, and to the collective automatons who sit behind them.

Another Greek word that means ‘to rule’ is *archein*. A **monarchy** is rule by a single authority such as a king or queen (Greek *monos* ‘alone’). **Anarchy** is a community without (Greek *an*) governmental authority. An **oligarchy** is government by very few people. (Greek *oligos* ‘few or small’). **Phenylpyruvic oligophrenia** stems from the same root. *Phren* is Greek for ‘mind’. The

disorder, therefore, results in "small-mindedness" or mental deficiency. And so we are back to politics.)

A **hierarchy** is government by the church. (Greek *hieros* 'sacred or holy'.) **Hieroglyphics** are the sacred pictographs (Greek *glyphein* 'to carve') of ancient Egypt, which were inscribed by the priestly class.

An **archbishop** is the ruling or chief bishop. (**Bishop**, by the way, comes from Old English *bisceop*, which in turn derives from Greek *epi* 'upon' and *skopein* 'to look'. A bishop, therefore, looks upon or supervises a diocese.) The **Episcopal** Church is ruled by bishops and has thus acquired its name. (Incidentally, the bishop's **miter**, a tall, ornamental cap with peaks in front and back, resembled the left atrioventricular heart valve to some imaginative prosecutor—thus the origin of the **mitral** valve.)

The bishop's chair or throne is called a *cathedra* in Latin. Eventually, the building in which he sat became known as a **cathedral**. And when someone speaks *ex cathedra*, he or she lectures with the full authority conferred by the chair or position held.

President derives from Latin *praesidere* 'to preside'. This in turn arises from the Latin word *sedere* 'to sit'. Obviously, the president must sit at the head of the executive table. He or she thus becomes the quintessential **chairman** or **chairwoman**. A **chairperson**, I suspect, must be sexually neutered.

The Roman **Senate** was manifestly comprised of old men (Latin *senex* 'ancient or old'). **Senescence**, which may have been perpetuated by that body, appears to have infected successive generations of incumbents throughout the world, culminating in our pandemic of benighted and incompetent legislators.

Quadrennially, our country develops a curious derangement. Politicians **caucus**, then go out on the **stump** appealing for citizen support. **Caucus** is the name of an early political and social club in Boston to which John Adams belonged. It derives from an Algonquin Indian word, *caucauas* 'counselor'. (The word **caucus** represents the total extent of political involvement our native Americans were permitted—until congress graciously allowed them to vote in 1924.)

To stump originates from the abundance of tree stumps that were to be found in colonial America—the result of clearing land for farming. A politician had but to step onto one of these natural platforms to deliver his speech. (The term "to be stumped" derives from the tenacity with which these arboreal remnants hold onto their birthplace, frustrating attempts by lesser beings to remove them.)

Finally it is time to **vote**—Latin *votus* 'a vow'. A vote cast is a vow of support for the candidate. (Would that it were reciprocated.) The **ballots** are then counted. **Ballot** is from Greek *ballein* 'to throw'. The word **ball** also issues from that root. The ancient Greeks voted by tossing a marble into a container. A white marble or ball represented a vote for the nominee. A black ball symbolized a vote against—thus the origin of **blackballing**. (The word **bullet** also derives from *ballein*. Occasionally, in certain precincts, this results in chaos at election time.)

Inescapably, the time comes to **inaugurate** the victor. (**Inaugurate** from the Latin *augere*, which in turn originates from *avis* 'bird' and *gerere* 'to handle'. In ancient times, the future was predicted by mystics, diviners, and oracles who prophesied by killing and dissecting birds, the entrails of which provided them with

their forecast. Before momentous occasions such as a great battle or a coronation, the augur would be summoned to exercise his predictive skills—usually to prophesy a victory for the incumbent ruler.

Some of these fortunetellers performed their sorcery by merely observing the flight patterns of certain birds. They were "bird watchers" (*avis* 'bird' + *spicere* 'to observe'. From this evolved the Latin *auspex*, which ultimately resulted in **auspicious**.)

Unfortunately, an inauguration is not always an **auspicious** occasion. ■

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A Look Back

Reprinted from the *Maryland State Medical Journal*. 1967; 16(1): 49-54.
Russell S. Fisher, M.D.

Dr. Fisher was chief medical examiner, Maryland Department of Postmortem Examiners.

The role of alcohol in traffic fatalities in Maryland

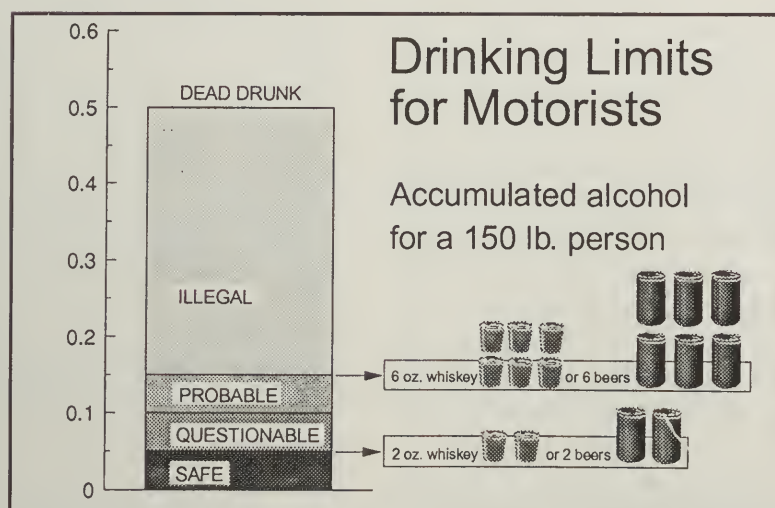
Before I show some of the grim statistics of traffic deaths due to driving while under the influence of alcohol, I would like to make a plea to those here who represent the public communications media to enter into the spirit of affirmative traffic safety education and accident prevention. By this I mean that, as in the case of the ten commandments, most of which begin, "Thou shalt not..." (for example, you shall not drive under the influence of alcohol, and you shall not drive carelessly), there is one greater commandment that boils down, as the Lord said, to "Love thy neighbor as thyself."

an active educational program on your part and on the part of all those who have access to the public mind, a program which does not merely say, "Thou shalt not drive carelessly", but which teaches us to drive safely.

Having indicated, therefore, that I think what can be done in prevention by legal enforcement is but a small part of what we need, I will do what I was asked to do here today: explain to you or show you some of the evidence that indicates that one medical condition, namely, an excess of alcohol in the system, is an important factor in the deaths that occur on our highways.

If we look at the scale on the left of the **Figure**, we can get some idea of the relationship of the level of alcohol in the system to our ability to be safe drivers. This slide shows blood-alcohol concentrations in actual percentages. Thus at the top we are dealing with one-half of one percent of alcohol in the blood. Fifteen hundredths of one percent is the level which, for many years, has been accepted as the absolute maximal blood-alcohol concentration for an individual still to be reasonably able to drive an automobile.

Indeed, as a result of studies in the past few years, all the national groups, including the American Medical Association and the National Safety Council, and all experts in the alcohol and chemical-testing fields, have agreed that only one-tenth of one percent is the level above which drivers are unfavorably influenced in their ability to control a vehicle. So we say, with no hesitation, it is highly probable that the individual is "under the influence" in the range of 0.10 percent to 0.15 percent, and it is certain that he is under the influence if



This is affirmative. It gives us something good to do instead of a lot of "thou shalt nots." I think if we are to solve the murder-on-the-highway traffic problem, it will take more than the police and the medical examiner, the state's attorney and the courts, in the thou-shalt-not phase. It will take

A LOOK BACK

his blood-alcohol level is above fifteen hundredths of one percent.

In Maryland, by law, one is presumed to be under the influence if his blood-alcohol level is shown to be

were in the low range, and it is difficult to say with any certainty that their behavior was influenced.

But there was a total of 18 percent whose blood alcohol level was in ex-

cess of this high concentration of alcohol and the extremely high proportion of drivers who were involved, and indeed killed, in fatal automobile accidents.

It is obviously true of course that, in addition to this 54 percent, some of the individuals who were killed, were killed by drunken drivers who did not happen to get killed and tested themselves. So the conclusion that more than half the drivers who met their deaths in vehicular accidents were, in some degree at least, victims of alcohol seems highly supported.

Table 2 takes us to the question of testing the non-fatal individuals on the road whose driving is thought by police at the time of their arrest to indicate they are under the influence of alcohol. In 1965, there were 663 drivers tested by the Maryland State Police under their breathalyzer testing program. Some 83 percent turned out to have .15 percent or more blood-alcohol. This means that the police, as a result of their experience in apprehending these individuals, believed when they saw them that they were under the influence; they asked them to take the test; the test was taken and it corroborated their original impression in 83 percent of the cases. Indeed, with the addition of another 12 percent of the 663 whose blood-alcohol was at the .10 percent to .14 percent level, there were actually 95 percent who had been

Table 1. Alcohol analyses in motor vehicle fatalities—1965

Drivers involved in fatal accidents	846
Drivers killed	274
Number of driver fatalities analyzed	149

Results of analysis of blood	% of total tested	
Negative	51	34
.01%-.05%	6	4
0.06%-.09%	12	8
0.10%-.14%	26	18
0.15% or more	54	36

fifteen hundredths of one percent or greater. Bearing these figures in mind, let us look at Table 1, which presents actual statistics for this state.

In 1965 there were 274 drivers killed in motor vehicle accidents on Maryland highways. It is part of the medical examiner's job to test the individuals who die as a result of violent death in motor vehicles to determine whether the driver had been drinking significantly.

Some drivers survive a number of hours or days after accidents and any alcohol present in the system at the time of accident would have been burned out by the time of death; these drivers are therefore not tested. When individuals die immediately, or within a few hours, their blood-alcohol level is automatically checked.

Of the 274 drivers who died in 1965, 149 were checked by our department. Reduced to percentages, reports on the tested drivers were negative for 34 percent: they had not been drinking. Another 4 percent had not been drinking significantly; they may have had a cocktail. We do not believe they were under the influence. There is another 8 percent who

were in the low range, and there were 36 percent in whom it exceeded .15%—a total of 54 percent, more than half of all the drivers tested after being killed on highways.

You may say, "Doctor, how do you know that the alcohol level which was evaluated had anything to do with their deaths?" I must admit this is a little difficult to prove, but I think you will agree with me that half of all the people driving the highways in the state of Maryland are not carrying blood-alcohol levels of above .10 percent. You would have to assume that would be equally true if you disagreed with me in the conclusion that the alcohol had something to do with their deaths. There has to be a rela-

Table 2. Results of breathalyzer tests by Maryland State Police—1965

Blood alcohol	Number	Percent of total
.05% or less	17	3
.06%-.09%	13	2
.10%-.14%	82	12
.15%-above	551	83
Total	663	100

A LOOK BACK

imbibing significantly, so that there seems no doubt their ability to operate a vehicle was impaired.

Obviously this information is useful in prosecution. It does help the police in their efforts to keep the drunken driver off the road. So why are we not doing better? Table 3, I think, answers this question very promptly.

We are not doing better with the chemical law, which is certainly one of the tools in enforcement in these cases, for the prime reason that of all people who were asked to take the test (the law requires that the test be offered on a voluntary basis), more than 40 percent refused. They did not cooperate with the police in providing evidence that indeed they were under the influence of alcohol, or were not, as the case may be.

I would mention very briefly, before we leave the subject, the 5 percent of individuals who were tested, and whose tests were negative. This is a side effect, you might say, a side benefit of the law—because it is important to “follow through” when an individual appears to be inebriated, and the chemical tests reveal that he in fact is not drinking at all. Obviously he is medically ill; there must be some other explanation of his apparent drunkenness. Of course these people end up in the hands of physicians who then treat their diabetes, or their drug intoxication, or whatever it may be that was misinterpreted as evidence of their being under the influence. This is simply a safety factor in protecting the non-involved individuals.

I want to go back to this for a minute because there has been a bill

before the state legislature for several years which would provide for what we call “implied consent.” If this were enacted, individuals who refused to take the test after having been arrested and charged with driving while under the influence, would be subject to loss of their driver’s license for a certain period. If one is to make the chemical test program effective as a means of discouraging driving while under the influence of alcohol, one must have a mechanism for using the test in all the cases in which the question has been raised. As it stands now, with 40 percent of the suspects refusing the test, the mechanism of prosecution is largely inactivated.

The police, the medical examiner, most individuals who are safety minded, believe that the implied consent law, which would subject the individual who refuses to take the test to at least a period when he would not be driving on the highways, is a good law, and one that we should have. We will not take the time to discuss it further here today, but I think it is important for all of you to recognize that part of the problem of vehicular accidents and deaths due to alcohol is enforcement, and part of the failure of enforcement is due to the inadequacy of the laws which provide the police with the tools for enforcement of the ban on driving while under the influence.

I have little more to add. I would summarize this simply by saying that there have been many studies of alcohol and driving. Our own experience through the years indicates that the figures I showed you for 1965 are about the same as they were ten years

ago. Between a third and a half of the drivers killed on the highways are under the influence; between a third and a half of the pedestrians killed have a high blood-alcohol level at the time they are struck; and even a good many of the passengers are under the influence at the time they are killed.

I can present the business of the pedestrian a little bit differently because basically you can divide the pedestrians into three groups. These are children who, foolishly and because they are children, jump out in front of automobiles. Of course the children have not been drinking. There is an elderly group—and I will not attempt to define that in years because each year “elderly” gets older than it used to be—and the elderly people are hard of hearing, or have visual deficiencies, or are impaired physically, so that they cannot dodge the oncoming car very effectively, and it is our experience that among these people about 25 percent to 35 percent will also have been drinking when they are hit as pedestrians.

The children make up about one-third of the victims, the elderly people about one-third of the victims, and then there is what we call a middle third, the people perhaps between fifteen years at the youngest and some ripe old age at the top. This middle third are of special concern to us because we wonder why should they be killed. I will tell you why: two-thirds of them are under the influence of alcohol at the time they are hit by an automobile.

I am convinced that alcohol has something to do with motor vehicle deaths. I believe that this opinion is held by all of the doctors in the state, and I hope whatever medicine can do to help curb this excessive use of alcohol, and thereby help to prevent the carnage on the highway, we will do. ■

Table 3. Breathalyzer tests by Maryland State Police—1965

Tests offered	1,114
Tests given	663
Tests refused	451
Percentage of refusals	40%

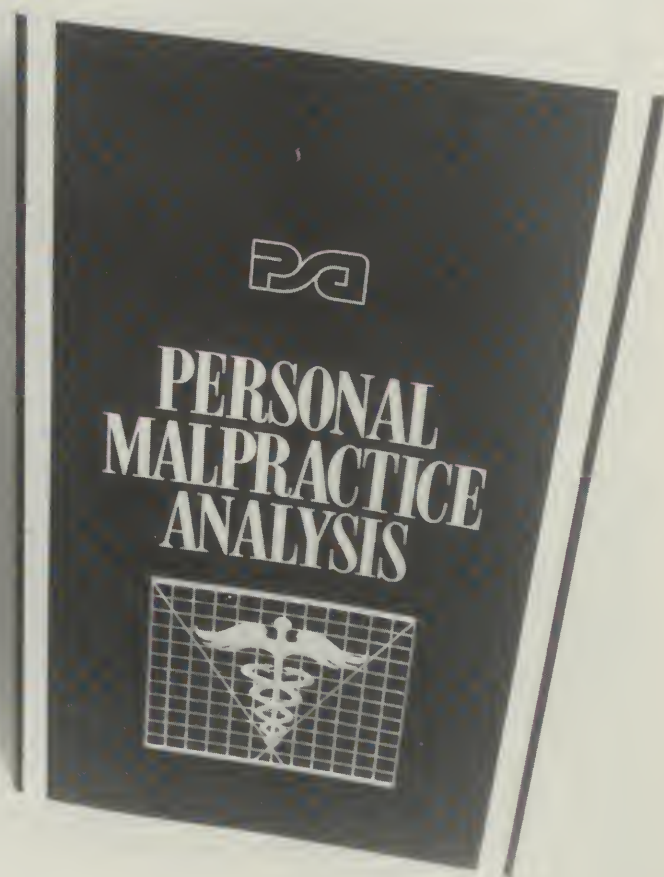
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Book Reviews

Max Brödel: The Man Who Put Art Into Medicine. Ranice W. Crosby and John Cody. New York: Springer-Verlag. 1991. 352 pages. \$49.00

Crosby and Cody have given the medical literary world a warm, comfortable, easily read report of the life of a genius in his form of art. The story centers upon Paul Heinrich Max Brödel, known as Mr. Brödel, Max, or even Papa.

Since the time of the incomparable Leonardo da Vinci over 400 years ago, no one had appeared in medical artistry who could match his talent. Although not as versatile as da Vinci, Brödel was more than an equal in art as applied to medicine. Interestingly, both were fascinated by music; da Vinci an autodidact at the lyre and Brödel at the piano.

Brödel was responsive to art and music from early on in his life. Because he apparently possessed a notable sense of rhythm, his father initiated piano lessons for him at six years of age. Brödel became adept at the instrument, and his playing gave him tremendous pleasure in later life. As his proficiency with the instrument increased, his father contemplated a musical career for the budding virtuoso, a thought seconded by his teacher. Fortunately for medical posterity, however, Brödel was more attracted to art, and he managed to be transferred to the Leipzig art school. Here, his work displayed a quality destined to lead him to stardom. Subsequently, by chance, he began work for Dr. Carl Ludwig, a Leipzig physiologist, and at this point, the events that eventually led him to the Johns Hopkins Medical School began to unfold.

Brought to the United States through the efforts of Dr. Franklin P. Mall, the head of the Department of Anatomy, Brödel was introduced to Dr. Howard A. Kelly, for whom he was to illustrate *Operative Gynecology*. Surrounded by the Hopkins greats—Welch, Kelly, Mall, Osler, and Halsted—Brödel, too, dreamed of notability.

This state he eventually achieved as he created a new method of producing

images of amazing palpability and realism. His fluidity, grace of touch, and use of light, accompanied by a masterly use of aerial perspective and focal distance, made his illustrations unique.

Brödel was paid one hundred dollars a month by Kelly, although the latter permitted the artist to accept private commissions to improve his financial status. Equally important, he received initial guidance from Kelly, who, although not an artist comparable with Brödel, was able to show by sketches how he wished the finished product to appear.

Through his work in Baltimore, Brödel met his future wife, Ruth, also a medical illustrator. After giving her preliminary instruction to initiate her work with Mall, he learned that she, too, was a pianist. They enjoyed many musical sessions, and, before long, marriage was in their plans.

The salary that Kelly paid Brödel, an established medical artist, was a mere pittance. The great Baltimore fire hurt the hospital financially in 1904, and Brödel thought seriously about work elsewhere. He visited the Mayo Clinic at that time, but the men in the higher echelons of the Hopkins hierarchy, even the departed Osler from Cambridge, urged him to remain in Baltimore.

In 1905, the board of the university ameliorated the situation slightly by appointing him an instructor in art as applied to medicine, but without pay. One year later, the department was recognized officially, and Brödel was appointed an associate professor.

Dr. William J. Mayo made a second attempt to lure Brödel to Rochester in 1906 by offering the artist a salary of five thousand dollars a year and proper credit in all publications. When the news spread, the Hopkins powers responded by giving him the same \$5,000 salary. Four years later, the clinic tried again when Dr. Mayo of-

ferred him the same salary, and, this time, Brödel was sorely tempted. The endowment of the Department of Art as Applied to Medicine by Henry Walters (whose art collection formed the core of the Walters Art Gallery) finally succeeded in keeping Brödel, now director, in Baltimore. The institution that Brödel had envisioned was finally a reality. During the preceding years, he had taught and lectured in his specialty, so further academic preparation was not needed to shift the enterprise into high gear. Medical students were offered a course in surface anatomy, and three times a year, Brödel held classes for mixed groups of residents, researchers, and faculty. His dream was to find students whose abilities could be fostered and brought to a serviceable level of competence, and, in a way, parallel the routes taken by many Hopkins clinical residents. If Halsted could create professors of surgery, Brödel thought that he could spawn superb medical illustrators. During these years, he had the added satisfaction of tutoring one of his daughters, Elizabeth. A goodly number of his trainees went on to head departments at medical schools and hospitals. Brödel may have been underpaid, but he attained the ultimate satisfaction of a good teacher by seeing many of his people in responsible positions. As a true mentor, what more could he ask?

The book concludes with five appendixes, each containing information that will have an appeal to a particular group of readers. The descriptions of the techniques are printed in the words of Brödel.

Brödel had a number of infectious diseases that not only threatened the continuance of his artistic ability but his life as well. In those years before chemotherapy of any kind, major infections from the streptococcus were frequently lethal. Brödel had the misfortune to have such an infection of the right upper extremity, and its treatment necessitated multiple operations. As healing progressed, he noted marked impairment of function in the area of

distribution of the left ulnar nerve. Careful clinical observation, buttressed by many sketches during the recovery period, convinced him that the nerve was bound by scar tissue and that he had what is now recognized as a tardy ulnar palsy. He prevailed upon Halsted to explore the region and perform a neurolysis. Brödel experienced an excellent functional result. Although the loss of use of half of his left hand would not have influenced his artistic ability, Brödel would have missed playing the piano. A severe session with typhoid fever, another bout with the streptococcus, and an injury to the right middle finger were other sources of stressful concern.

Although Hopkins regularly dignifies its important individuals, Brödel, for some unknown reason, was not so honored. In 1937, one of the major book publishers marked the fiftieth anniversary of its first medical copyright by a dinner given for Brödel. The outpouring of love and compassion evidenced at the occasion by the all-male gathering was wonderful. Even Henry L. Mencken, the Baltimore literary light, was there to lighten the mood of the affair. As a member of the Saturday Night Club, Brödel played the piano with Mencken, who gave his comical view of Brödel as a performer.

The authors are well suited, particularly Ranice W. Crosby, to write this obvious labor of love. She studied with Brödel and later became head of the Department of Art as Applied to Medicine. Dr. John Cody was trained by Crosby.

JOSEPH M. MILLER, M.D.
Timonium



The Prostate Book: Sound Advice on Symptoms and Treatment. Stephen N. Rous. New York: W.W. Norton and Company 1992. 285 pages. \$22.95

The author is well qualified to write this text. A trained urologist with many medical publications, he is now serving his third professorship during his professional career. He states that he has written a book for that large

segment of the lay, male population who have or who will have difficulty of some type with the prostate gland. The text reaches further than this group, however, as physicians in general and family practice and medical students will benefit from these easily followed descriptions of diagnosis and therapy. The normal anatomy, function, and diseases of the prostate are carefully considered. Laboratory tests necessary for diagnosis are explained in language that the uninitiated person may easily follow.

The individual with benign prostatic hypertrophy will visualize and understand the cause of his obstructive uropathy and will know why values for serum urea and creatinine may be elevated. Differences between the obstruction caused by a hypertrophied prostate surrounding the urethra and a median bar are elucidated and presented in diagrammatic fashion so that the various types of operative attack may be understood.

Rous introduces the reader to the use and advantages of the excretory urogram, renal scan, computed tomography scanning, and magnetic resonance imaging, all of which may be components of the diagnostic armamentarium. Should malignant neoplasia enter the differential diagnosis, roentgenograms of the pelvis and lumbar vertebrae will be found useful.

Catheterization of the urinary bladder and cystoscopy are further helpful tools. The presence of a discrete, hard nodule in the gland may necessitate removal of tissue for microscopic examination by one of several techniques. All of the procedures are given lengthy explanations to alleviate the fears of prospective patients about their use.

Interference with sexual activity as a consequence of having surgery for prostatic difficulties is dreaded by many men. Rous dispels the accompanying myth and explains why most of these procedures do not interfere with such activity. Loss of the ability to father a child may occur, however, because retrograde ejaculation exists in a significant number of patients



undergoing surgery for benign prostatic hyperplasia.

Radical prostatectomy for carcinoma is reviewed, and the complications associated with this procedure are discussed. Rous reasons that patients who give genuinely informed consent and understand what the contemplated operation entails will frequently have an easier postoperative course and a preferable therapeutic result.

Four years after writing the original text, the author added a final section in which he considers new knowledge gained in the interim. Determinations of prostatic specific antigen as a diagnostic feature of carcinoma of the prostate have permitted further advances in the determination of proposed therapy. Ultrasound guidance in the removal of prostatic tissue for microscopic examination is a distinct help. A number of alternative nonsurgical procedures to improve the status of the patient with benign prostatic hypertrophy are also explained. Balloon dilatation of the prostatic urethra, transurethral incision of the prostate, hyperthermia of the prostate, transurethral laser incision of the prostate, ultrasonic aspiration of the prostate, the use of stents and coils in the prostatic urethra, and drug therapy are reviewed. Some of these operations will be beyond the understanding of the individual patient, and they could have been profitably omitted from the book, although their usefulness to the medical profession and students cannot be contested.

A glossary forming the last portion of the text thoughtfully defines the medical and surgical terms used. The medical student will find this area particularly valuable.

Men seeking relief from prostatic disease may go to a urologist a little earlier after reading this book and prevent further damage to the urologic system. Other males, needing therapy, may be given a certain degree of salutary confidence by having their questions answered.

JOSEPH M. MILLER, M.D.
Timonium

Psychosurgery: Damaging the Brain to Save the Mind. Joann Ellison Rodgers. New York: Harper Collins Publishers. 1992. 249 pages. \$20.00

Lewis Carroll may epitomize the thoughts of a reviewer of this book by relating an incident involving Alice in *Through the Looking Glass*.

Alice laughed. "There's no use trying," she said. "One can't believe impossible things."

"I dare say you haven't had much practice," said the Queen. "When I was your age, I always did it for half-an-hour a day. Why, sometimes I've believed as many as six impossible things before breakfast."

The surgical treatment of psychiatric disorders—the core of attention of this study—centers around the ablation of continuity of nerve structures of the limbic system, the area of the brain involved with emotion and external bodily responses to stimulation. Impulses are transferred to and from the hypothalamus and cortex through the limbic system. The basic functions of this complex and fairly extensive neural network contribute to the continuation of the species and the preservation of the individual; they include feeding, aggression, emotion, and the autonomic and endocrine expression of the sexual response.

The rationale supporting the surgical approach to some psychosomatic diseases is that interruption of one part of the pathway will modify the behavioral response and emotions of the sick individual. A secondary aspect of this thought is that neurochemical changes after such disruption may also produce a salutary effect.

The introduction of frontal lobotomy initiated a series of procedures differing from each other in the extent of the induced trauma. Many of these operations were engendered in desperation as they were performed on as-

saultive, suicidal, homicidal, and overactive patients who had not responded to conventional therapy. Early reports of operative results in psychotic individuals were in terms of "improvement." Subsequently, malfunction of a part or parts of the limbic system was introduced as an etiologic factor, and operations were directed toward more selective areas. Lesions were then made in the limbic structures, such as the cingulum, amygdala, and mid-line thalamic area.

The advent of stereotaxis in psychosurgical operations allowed for more accurate placement of the destructive lesions so that surgical complications were reduced in number. The use of such procedures in psychiatrically disabled World War II veterans contributed to the growing number of all types of these operations at that time. Because psychoactive drugs later offered more predictable results than invasive procedures, lobotomy eventually fell into disfavor despite its initial popularity.

The wide spectrum of thought about the use and efficacy of psychosurgical procedures, and an underlying conviction that more good than harm was generated by these operations, led the author to conduct an intensive review of patients, psychiatrists, neurosurgeons, and the pertinent literature. Readers will be left with the impression that the book, although written for a limited audience of interested relatives and workers in the psychiatric field, was not written in a vacuum. One flaw in the report is that the author did not cross-index the references with the text, which will cause some difficulty for the individual seeking first-hand information about therapy.

Operative interference with the function of the limbic system was directed toward altering mood and behavior. The horrendous period of the ice pick lobotomy and some of its cousins initiated a critical, in-depth survey. Malpractice law also necessitated that the patient give informed, written consent. In some institutions, committees were established to study the individual

proposal at length before hospital permission for the performance of the operation was granted.

Damaging the brain to save the mind is now a most controversial issue. Rogers reports that doctors and hospitals will encounter great difficulty in conducting trials of established or new procedures for psychiatric disorders. This obstruction may be overcome by understanding more precisely how the brain works, but surely this must be a most formidable task.

The long-term results of one study of 300 patients was reported to be "largely very good" and, in another study, full recovery in 13 percent. The critical physician is not apt to accept these numbers favorably in making a recommendation for a patient.

Early psychosurgeons were ignorant of the more intricate knowledge of space relationships within the brain that are now made possible by computed tomography, magnetic resonance imaging, and positron emission tomography,

as well as many of the chemical reactions involved in brain function. Although recently trained surgeons in this field have the advantage of this information and these techniques, the multitude of neuron pathways and their individual and collective function still remain a mystery.

Dr. Geoffrey Cureton Knight was one of the pioneers of this new type of surgery, with perhaps one of his greatest contributions being stereotactic subcaudate tractotomy, an operation created through the desire to do minimal brain damage with maximal beneficial therapeutic change. Intense study delineated specific areas of the frontal lobe that received and sent impulses concerning emotion and behavior. Stereotactic devices permitted more accurate placement of the lesions. Now the procedure of choice, the operation employs a bifrontal approach through small burr holes and the insertion of probes. Roentgenography is then used to certify the desired placement, after

which radioactive material is used to inflict the necessary trauma. In the clinic with which Dr. Knight was associated, more than 1,000 such operations have been done with full or almost complete recovery being experienced in about 50 percent of previously selected patients and an additional 20-30 percent having some relief. The remainder were unaffected. Why all patients do not respond, and why a variability in response time in the more favorable patients exists, must yet be ascertained.

The problems of who should receive surgery and the best means of attaining satisfactory results have not yet been answered. For the lay public, Rogers has provided an in-depth review that will help relatives of psychiatric patients needing such a procedure reach a decision more easily.

JOSEPH M. MILLER, M.D.

Timonium ■

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COMING OUT OF THE DARK

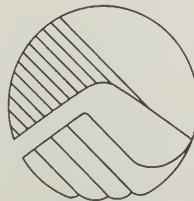
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Members in the News



EDWARD A. CARTER, M.D., a radiologist at Carroll County General Hospital (CCGH), has been elected to a third term as president of the hospital's medical staff, which represents more than 250 physicians with admitting privileges at the Westminster hospital.

As medical staff president, Dr. Carter chairs the Medical Executive Committee as well as the Medical Review Committee, which deals with quality assurance issues. He is also a member of the hospital's board of directors, serving as chief liaison and spokesperson for the interests of physicians in hospital affairs.

Dr. Carter, who has practiced at CCGH for 15 years, was also re-elected chairperson of the Department of Radiology.

A graduate of the University of West Virginia, Dr. Carter attended medical school at the University of Maryland, and completed his residency at the University of Maryland Hospital. After enlisting in the US Air Force, Dr. Carter was assigned to the US Air Force base in Ramstein, Germany, where he was chief of Radiologic Services. He left the military in 1977 for private practice.

Federation for Clinical Research, the American Society of Internal Medicine, the American Heart Association, the Mid-Eastern Chapter of the Society of Nuclear Medicine, the Maryland Society of Nuclear Medicine, the Johns Hopkins Medical and Surgical Association, and the Baltimore County Medical Association. He teaches at Johns Hopkins School of Medicine and the University of Maryland School of Medicine and has written numerous articles on nuclear medicine.



JAMES P.G. FLYNN, M.D. has been chosen as the recipient for the American Lung Association of Maryland's 1992 George Wills Comstock, M.D. Award for outstanding contributions in helping people with lung disease. The George Wills Comstock, M.D. Award is presented in recognition

of extraordinary lifetime service to the goals of the American Lung Association in further promoting respiratory health through care, teaching, and/or research.



PABLO E. DIBOS, M.D., recently accepted the office of president of the medical staff of Franklin Square Hospital Center. Dr. Dibos has served as director of the Department of Nuclear Medicine and as chief of the Section of Nuclear Medicine, Department of Internal Medicine, at

Franklin Square since 1971. A native of Peru, Dr. Dibos came to Baltimore in 1965 to complete his internship and residency training. As an active member of Med Chi since 1971, he has served on the Faculty's Peer Review Committee from 1985 to 1990 (as chairperson from 1989 to 1990), and on both the Peer Review Management Committee and the Focused Professional Education Committee since 1991. Dr. Dibos holds memberships and offices in numerous other medical organizations, including the European Association of Nuclear Medicine, the American



MORTON F. GOLDBERG, M.D. has received a grant of \$75,000 from Research to Prevent Blindness (RPB) to support research into the causes, treatment, and prevention of blinding diseases. RPB is the world's leading voluntary organization supporting eye research.

Dr. Goldberg is director of the Department of Ophthalmology of the Wilmer Ophthalmological Institute and ophthalmologist-in-chief at the Johns Hopkins Hospital. He received his undergraduate degree in biology from Harvard College and his medical degree from Harvard Medical School. He completed his internship at the Peter Bent Brigham Hospital in Boston, MA and his residency at the Wilmer Ophthalmological Institute at the Johns Hopkins Hospital. He is a board certified diplomate of the American Board of Ophthalmology. Dr. Goldberg's sabbatical activi-

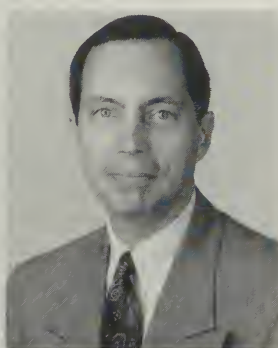
ties include Linacre College, Oxford University; London School of Hygiene and Tropical Medicine; and the Eye Hospital, Oxford, England. Dr. Goldberg has held many positions for various associations, committees, and institutions and is a prolific author and lecturer.



HARRY C. KNIPP, M.D. has been named as a fellow of the American College of Radiology (ACR). Selected for his outstanding contributions to the field of radiology, Dr. Knipp was named as one of 144 new fellows by the college's Board of Chancellors. ACR, a national organization

serving some 28,000 radiologists, radiation oncologists, and radiological physicists, awards fellowships to members for significant scientific or clinical research in the field of radiology or significant contributions to its literature.

After graduating from Loyola College in Baltimore, Dr. Knipp attended the University of Maryland School of Medicine and completed his internship and residency as well as a fellowship at the University of Maryland Hospital. Dr. Knipp is currently a clinical assistant professor, Department of Diagnostic Radiology, University of Maryland School of Medicine. He resides in Reisterstown with his wife Nora and their three children.



HERBERT LEE MUNCIE, JR., M.D., has been promoted to chairperson of the Department of Family Medicine, University of Maryland School of Medicine. A graduate of the University of Georgia he attended the Medical College of Georgia, and completed a family practice

residency at the University of Maryland Hospital. Dr. Muncie is chairperson of the Family Practice Section of the Southern Medical Association and serves as a member of the *Maryland Medical Journal's* editorial board. He is the author of numerous publications, is an accomplished

speaker, and has been highly successful in obtaining research funding for the University of Maryland.

Dr. Muncie resides in Severna Park with his wife Mary and their two children.



ARNALL PATZ, M.D. has been designated to receive the Association for Research and Vision in Ophthalmology's 1993 annual Mildred Weisenfeld Award for Excellence in Ophthalmology. This honor, created in 1986, is presented to an individual in recognition of distinguished scholarly contributions to the clinical practice

of ophthalmology. Dr. Patz is a professor emeritus of ophthalmology and former director of the Wilmer Institute at the Johns Hopkins Medical Institutions. He received his undergraduate degree from Emory University in Atlanta, Georgia and his medical degree from Emory University School of Medicine. He also holds honorary Doctor of Science degrees from the University of Pennsylvania and Thomas Jefferson University. He received his residency training at the Walter Reed Army Medical Center, Department of Ophthalmology. Active in countless professional societies, Dr. Patz is a prolific writer on eye disorders. He is the recipient of numerous awards for his research and achievements in ophthalmology.

HENRY P. LAUGHLIN, M.D. was elected as the inaugural president of the Council of Presidents of the Maryland Sons of the American Revolution (SAR). In addition to being a former state SAR president, Dr. Laughlin is a former national SAR surgeon general, former national SAR vice-president general, and has been a member of or chaired nine significant national SAR committees since 1985. The Sgt. Lawrence Everhart Chapter, SAR of Frederick County, also honored him earlier by electing him their honorary life president on April 4, 1988. (See photo on next page.) ■



The Council of Presidents, MDSSAR—Inaugural Meeting

Seated, l. to r., are Adm. Henry P. Laughlin, M.D. of Frederick County; Charles H. Williams, M.D. of Charlestown; Carl F. Bessent; Harold E. Wilmoth; and Elmer M. Jackson, Jr. Standing, l. to r., are Charles B. Slaughter, Esq.; James A. McCafferty; M. Page D. Laughlin; Irma P. Nicholson; Margaret Williams; Anne H. and Prof. Barrett L. McKown; Herbert L. Sr. and Fredrica B. Baer; Helen A. and Robert H. McIntire; and Doris Jackson.

ANNOUNCEMENT

TO

ALL LICENSED MARYLAND PHYSICIANS SOLICITATION OF NOMINATIONS TO THE BOARD OF PHYSICIAN QUALITY ASSURANCE

Pursuant to §14-202 of the Health Occupations Article of the Annotated Code of Maryland, all licensed physicians in Maryland wishing to nominate candidates for initial vacancies on the Board of Physician Quality Assurance may submit nominations to the following address *by January 22, 1993*.

BPQA vacancies

The Medical and Chirurgical Faculty of Maryland
1211 Cathedral Street
Baltimore, Maryland 21201

Persons making nominations must certify that the nominee is willing to serve and is a practicing licensed physician as required by §14-202.

Please note that an election to select the names of physicians to be submitted to the Governor for possible nomination to the BPQA, *open to all licensed physicians in Maryland*, will be held on April 30, 1993, at the University of Maryland Center for Adult Education in College Park. Time and location of balloting will be announced in an upcoming issue.

In Memoriam

John S. Harrington, M.D.

JOHN S. HARRINGTON, M.D., an obstetrician and gynecologist, died May 23 at the age of 69. He had Parkinson's disease. A Georgetown University Medical School graduate, Dr. Harrington served his internship and residency in obstetrics and gynecology at Providence Hospital. He served in the Army during World War II and with the Air Force during the Korean War. A diplomat of the American Board of Obstetrics and Gynecology, Dr. Harrington was chairperson of the Obstetrics and Gynecology Department at Providence Hospital and served as the hospital's medical staff president in 1985 and 1986. A member of the Montgomery County Medical Society, Dr. Harrington was also a member of the medical staff at Holy Cross Hospital and maintained a practice until his retirement in 1990.

Herbert J. Jacobs, M.D.

HERBERT J. JACOBS, M.D., a pediatrician, died of leukemia on October 7 at the age of 69. A graduate of the Hahnemann Medical College in Philadelphia, Dr. Jacobs served in the US Army Medical Corps from 1950 to 1956. After leaving the military, Dr. Jacobs practiced in Silver Spring and became chief of pediatrics at Holy Cross Hospital. In 1977, Dr. Jacobs was named physician of the year by the pediatric societies of Montgomery and Prince George's counties. A year later, Dr. Jacobs began working as a physician adviser to the Social Security Administration until his retirement in 1991. He was a member of the Montgomery County Medical Society, the American Academy of Pediatrics, and the American Medical Association.

Dudley P. Jackson, M.D.

DUDLEY P. JACKSON, M.D., 68, a hematologist, died September 15 after a heart attack. After earning his medical degree from the Johns Hopkins School of Medicine, Dr. Jackson served in the Navy at the Naval Medical Research Institute in Bethesda until 1951. Dr. Jackson continued his association with the Johns Hopkins Medical Institutions until 1972 when he accepted a position as chairperson for the Department of Medicine at Georgetown University Hospital. In 1982, Dr. Jackson became the association director of the training program in internal medicine. In addition to his work at Georgetown, Dr. Jackson was

a consultant to a number of organizations, published numerous articles, served as editor of several medical journals, and was editor of a section on hematology in an internal medicine textbook. An affiliate member, Dr. Jackson was vice-president of the Johns Hopkins Medical and Surgical Association, served as recorder for the American Clinical Climatological Association, and was a fellow of the American College of Physicians. He was also a member of the Medical Society of the District of Columbia, the American Physiological Society, the American Federation for Clinical Research, the American Society for Clinical Investigation, and the American Association for the Advancement of Science.

John Josselson, M.D.

JOHN JOSSELSO, M.D., 48, died October 8, 1992 after a three-year battle with cancer. An associate professor in the Division of Nephrology with the University of Maryland Medical Center, Dr. Josselson received his medical degree from the University of Michigan. He served his residency at University Hospital in Boston and the University of Michigan Medical Center in Ann Arbor. Upon completion of his service with the US Army's medical research division, Dr. Josselson began a renal fellowship at the University of Maryland Hospital and became a member of the faculty in 1977. A member of the Baltimore City Medical Society, Dr. Josselson was an active member of the Maryland Commission on Kidney Disease and also served as physician director of the Independent Dialysis Foundation, Marlboro Center.

C. Edward Leach, M.D.

C. EDWARD LEACH, M.D., a retired cardiologist, died October 17 of Alzheimer's disease and complications after surgery. After earning a medical degree from Duke University, Dr. Leach served his internship at the Johns Hopkins Hospital and his residency at the hospitals at Duke and what is now Case Western Reserve University. After serving as a research fellow at Massachusetts General Hospital, Dr. Leach established a private cardiology practice in Baltimore which he maintained for 48 years before retiring in 1988. A member of the Baltimore City Medical Society and the American Medical Association, Dr. Leach served on the staffs at the University of Maryland, Bon Secours, and St. Agnes hospitals.

William M. Seabold, M.D.

WILLIAM M. SEABOLD, M.D., 85, a pediatrician, died of pneumonia on May 28, 1992. A graduate of the University of Maryland Medical School, Dr. Seabold completed his internship and residency at University Hospital and Children's Hospital in Boston. In the mid-1930s Dr. Seabold moved to Catonsville and maintained a private practice until he accepted a fellowship to study adolescent medicine at Children's Hospital in Washington, DC. Later he joined the faculty at the University of Maryland as assistant professor of pediatrics. Before retiring in 1981, Dr. Seabold developed procedures for giving premature infants intravenous fluids and he helped develop improvements in blood replacement in infants and treatment for Rh incompatibility. He was a member of the Baltimore County Medical Association.

Clifford J. Turner, M.D.

CLIFFORD J. TURNER, M.D., a radiologist, died as a result of a plane crash on September 5, 1992. He was 51 years old. Dr. Turner received his medical degree from Hahnemann University in Philadelphia. In 1989, Dr. Turner founded Potomac Imaging Associates, in Fairfax, Virginia. Dr. Turner was a member of the Montgomery County Medical Society.

Huntington Williams, M.D.

HUNTINGTON WILLIAMS, M.D., a former Baltimore City health commissioner, died in his sleep on May 4, 1992 at the age of 99. While a medical student at Johns Hopkins in 1918, Dr. Williams entered the new School of Hygiene and Public Health where he received his medical degree in 1919 and a doctorate in public health in 1921. After interning in Montreal at the Royal Victoria Hospital, Dr. Williams became a district state health officer in Albany, NY. In 1931, he moved to Baltimore where he worked as director and assistant commissioner of the Baltimore City Health Department and was ultimately promoted to health commissioner in 1933. During his tenure from 1931 to 1962, Dr. Williams worked for the passage of Baltimore's Hygiene in Housing ordinance, opened a series of district health offices, and led campaigns to restrict use of lead paint, fluoridate water, and initiate a school dental program. During World War II, Dr. Williams was a consultant with the US Office of Civil Defense and traveled to London to study the effects of the blitzkrieg. In addition to his efforts during the war, Dr. Williams participated in a panel

of experts that advised the World Health Organization. He was also a professor of hygiene and public health at the University of Maryland School of Medicine and a lecturer and adjunct professor at the Hopkins School of Hygiene and Public Health. A member of the Baltimore City Medical Society, Dr. Williams was a fellow and former vice-president of the American Public Health Association, an honorary member of the Society of Medical Officers of Great Britain, and founder and first president of the US Conference of City Health Officers.

Information on the following physicians was not available at press time:

William D. Aud, M.D. Montgomery County Medical Society	4-29-92
Gilbert W. Benjamin, M.D. Baltimore City Medical Society	5-20-92
Edward Davens, M.D. Baltimore City Medical Society	9-8-92
Martin W. Donner, M.D. Baltimore City Medical Society	4-13-92
Paul V. Lemkau, M.D. Calvert County Medical Society	4-26-92
Miguel A. Rodriguez, M.D. Montgomery County Medical Society	
Dayton O. Watkins, M.D. Prince George's County Medical Society	7-3-92
James A. Weinberg, M.D. Baltimore City Medical Society	8-27-92
Samuel P. Wise III, M.D. Dorchester County Medical Society	5-21-92
Ali H.Z. Youssef, M.D. Montgomery County Medical Society	
Eva N. Zartman, M.D. Anne Arundel County Medical Society ■	5-8-92

*Please send information for In Memoriam to
Wanda Griebel
Membership Services
Med Chi
1211 Cathedral St.
Baltimore, MD 21201-5585*

Auxiliary

Introducing the 1992-1993 presidents



Charito M. Menchavez
(Mrs. Elmaslias D.)

ALLEGANY COUNTY—Allegany County's new auxiliary president, "Chit" Menchavez, has been involved with the auxiliary for 15 years. She hopes to increase membership and enhance the enthusiasm of the members.

Chit is married to a pediatrician who is a past delegate of the medical society. They have two sons. Tennis occupies her free time.



Socorro Lindado
(Mrs. Ramiro R.)

HARFORD COUNTY—Harford County's new president is a 16-year veteran of the auxiliary. Socorro hopes to increase membership and the amount of scholarship money available. She would also like to have as many members as possible certified in CPR (cardiopulmonary resuscitation).

Socorro's husband, Ramiro, is a pathologist and member of the county medical society. They have three children, two daughters and a son. As a part-time nurse at Franklin Square Hospital and auxiliary president, Socorro has little free time. She does enjoy sewing. Her latest project was making 40 favors for her oldest daughter's shower; the wedding was in September.

ANNE ARUNDEL COUNTY—Denise K. Matteson (Mrs. David E.) has been involved with the auxiliary for the past three years. This year, the auxiliary is beginning a new project in the schools on helmet safety; bike safety day will be sponsored in May (bike safety month).

Her husband, David, is a general surgeon with a subspecialty in colon and rectal surgery. He is an alternate delegate for the county medical society and a representative to the state. The Mattesons have a daughter and son. Denise's outside interests include tennis and horseback riding.



Anne M. Bolen
(Mrs. George)

MONTGOMERY COUNTY—A three-year auxiliary, Anne has a busy year planned. Public health is an important goal. The Montgomery County Auxiliary is involved with the Breast Cancer Task Force in developing a coupon book for pre-and post-natal care. Montgomery County has the highest breast cancer rate in the country. The AMA-ERF fund-raiser will be a musical

and comedy review "of, for, and by the doctors."

Anne is married to a gastroenterologist. The mother of two sons, Anne—a freelance editor—is also on the school board of the Harbor School and chaired her neighborhood July 4th parade.



Carolyn G. Smith
(Mrs. George I., Jr.)

FREDERICK COUNTY—Carolyn has been an auxiliary for four years. She hopes to increase membership and hopes that the auxiliary will be able to donate more money to Hartley House (a home for battered women and children) and the homeless.

Her husband George is an internist and a past president of the medical society. The

Smiths have a son and daughter. Carolyn also volunteers through the hospital auxiliary and oversees the care of her elderly parents in Georgia. She enjoys biking with her husband, walking, tennis, and bridge.



Nancy G. Warren
(Mrs. William A.)

PRINCE GEORGE'S COUNTY—An auxilian for 11 years, Nancy has specific goals planned for the coming year. The auxiliary will be actively involved in women's issues. The auxiliary will cosponsor forums and seminars on such topics as breast cancer and osteoporosis. A luncheon and fashion show will help to raise funds. Nancy be-

lieves that physician spouses need to be more visible and make others aware that they are interested in their county's well-being.

Her husband practices internal medicine and pulmonary medicine and is involved with legislative issues through the medical society. Nancy is very interested in her children's (a son and daughter) education and works with the PTA of both their schools. She is a member of a federated garden club, and serves on many church committees. Four times a year she sells Doncaster clothing. She also enjoys family visits to their home on a outer barrier island off of North Carolina.



Gail Metzner
(Mrs. Stephen E.)

WASHINGTON COUNTY—Eight years of experience in the auxiliary has made Gail stress the importance of involvement and of strong communication with the membership. The Washington County Auxiliary will be involved with a chapter of Y-ME, a breast cancer support group. There will also be a program on family violence. In addition,

a fund-raiser for the legislative fund will be held on election night. Voter registration materials will be made available and displayed in hospitals. The auxiliary will also try to raise \$1,000 for CASA, a home for battered women and children.

Gail's husband, Stephen, is in family practice. He is also the chief of the Family Practice Division of the county medical society. Outside interests for Gail in-

clude a gardening club, needlepoint, counted cross-stitch, and a gourmet dinner club and birthday club.

WICOMICO COUNTY—Christine M. Abrons (Mrs. S. Albert) has been a member of the auxiliary for eight years and hopes to continue the programs of education in the schools addressing AIDS, Organ Annie, and Organ Aprons. The county auxiliary will donate the book *Blood and Guts* to the schools. Organ Annie is also being taken to MAC, program centers for seniors; it has been very well received.

Her family includes her family practitioner husband and their two daughters. Christine volunteers in the schools and community, and enjoys bike riding and reading.



Baltimore City
Adriana Zarbin
(Mrs. Gino)

THE FOLLOWING COUNTIES have been fortunate in being able to persuade their president from last year to continue on in that position for this year: **Kent County** Elizabeth A. Donovan (Mrs. David C.) (Not pictured) ■



Baltimore County
Dianne Nagel
(Mrs. J. David)



Charles County
Fatima Haziq
(Mrs. Mohammed)

Inpatient Treatment For Dissociative Disorders

Under the direction of Dr. Richard J. Loewenstein, Sheppard Pratt's treatment program is based on the view that dissociative disorders are readily diagnosed and treated. Utilizing the Armstrong-Loewenstein Dissociative Disorders Assessment Protocol as a baseline, individual treatment planning is determined and the master treatment plan can include:

- intensive therapy specifically designed for people with histories of trauma and abuse;
- psychopharmacology;
- cognitive therapy;
- adjunctive hypnotherapy;
- stress management;
- managed milieu that teaches safe coping skills for symptoms such as: switching, dissociation, amnesia, and flashbacks;
- and a full range of expressive therapies.
- The staff of the DDU also provides education and therapy for the patient's present day family with assessments available for children.

Sheppard Pratt's DDU is available to adult patients with dissociative disorders or other chronic childhood onset, post-traumatic conditions who are:

- newly diagnosed and are unstable or;
- in acute crisis or are decompensating or;
- involved in working through difficult therapy material requiring a safe, secure setting or;
- dangerous to self or others and/or self mutilatory.

For more information or to make a referral, call: Dr. Susan Wait, coordinator for the inpatient DDU at (410) 938-5070.

Sheppard Pratt
A not-for-profit health system

Maryland's Mental Health Resource

6501 N. Charles Street

Box 6815

Baltimore, Maryland 21285-6815

Medical Miscellany



Med Chi portrait on loan to National Portrait Gallery

The historical collection at Med Chi contains many fine examples of American portraiture. Visages of founders and members decorate the halls of the Faculty building. The portrait of Horace H. Hayden (1769–1844) by noted American artist Rembrandt Peale is currently on loan to the National Portrait Gallery for the exhibit *In Pursuit of Fame: Rembrandt Peale, 1778–1860*. The exhibit integrates the art of portraiture with the social history of the early republic as expressed in the career and works of one of America's important nineteenth century artists.

Horace H. Hayden was born in Windsor, Connecticut in 1769. He trained first as an architect and later turned to dental surgery. He is best known as a founder of the Baltimore College of Dental Surgery, the first dental school in the world. Hayden also served as a surgeon during the War of 1812, aiding the wounded during the Battle of North Point (1814). Hayden's interests extended to geology and his investigations led to the discovery of the mineral Haydenite, a yellowish variety of chabazite.

The exhibit runs from November 6, 1992 through February 7, 1993. The National Portrait Gallery is located in Washington, DC at F and 8th Streets, N.W.



Editor presents best article award

On October 1, 1992, Editor Victor R. Hrehorovich, M.D. presented Mary Betty Stevens, M.D. with a plaque honoring her selection as the author of the 1991 best *MMJ* article. The award honors the physician writer whose proficiency in sharing with colleagues the results of research surpasses all other authors whose manuscripts were published in the journal that year. In presenting the award at the Maryland Lupus Foundation's annual meeting, Dr. Hrehorovich noted that Dr. Steven's paper, "The Clinical Spectrum of SLE," was a thorough, well-written, carefully researched treatise on a condition with which many physicians are relatively unfamiliar. Dr. Steven's exemplary manuscript, chosen from a field of 71 papers, was published in a special October issue of the *MMJ* focusing on systemic lupus erythematosus; Dr. Stevens was the coordinator of that special issue. ("Inflammatory Pseudotumor of the Retroperitoneum" by Santa J. Johnston, M.D. et al was chosen as the best 1991 *MMJ* article by a resident.)

Contract physicians needed for women's cancer protection program

The Baltimore County Department of Health will be contracting with internists, family practitioners, obstetricians, gynecologists, and radiologists to perform clinical breast examinations, pelvic examinations, Pap smears, and screening and/or diagnostic mammography services for women aged 50 and over who are enrolled in the health department's new Women's Cancer Protection Program. Reimbursement for these services is uniform, pre-set by the health department, and competitive with standard rates. Bid packages outlining requirements and reimbursement details may be obtained by calling the Baltimore County Office of Central Services at 410-887-3857. To request application materials, ask for bid packages by name and number

<i>Physician services</i>	R-9304653
<i>Radiology services</i>	R-9304654

A pre-bid conference will be held on Monday, November 16, at which time any questions may be asked of the program's administrative staff. Deadline for application submission is December 1. For more information, call the health department at 887-3432.

Independent study guide on vision loss

An 80-page independent study guide for physicians to help older patients with vision loss is available from The Lighthouse, Inc. *The Aging Eye and Low Vision: A Study Guide for Physicians* can help physicians

- identify patients with age-related vision changes,
- suggest strategies to deal with vision loss,
- refer patients for appropriate vision services, and
- establish communication with eye care professionals on patients' overall care

This program has been reviewed and is acceptable for two prescribed hours by the American Academy of Family Physicians. Physicians may obtain a complimentary copy of the study guide by calling 1-800-334-5497 or writing Lighthouse Low Vision Products, 36-02 Northern Blvd., Long Island City, NY 11101.

American College of Physician Executives offers scholarships

The American College of Physician Executives (ACPE) is seeking applicants for three scholarships worth more than \$4,500 each. The scholarships are awarded annually to physicians who are employed in health care organizations that provide service in areas

that are medically underserved or that rely predominantly on public or charitable funding.

Scholarship applicants must be employed by a government agency or an organization qualified for tax exemption under Section 501(c)3 of the US Internal Revenue Code. The scholarship's purpose is to promote management development and training. Each scholarship includes tuition and a per diem for expenses for attendance at ACPE's national conference, May 11-15, 1993, in New Orleans.

To apply, applicants should send a letter explaining how the training will benefit them and their organization; demonstrating that a need for the scholarship exists because funding for such training is not available within their organization; showing what percentage of the organization's revenues are derived from federal funds, state funds, patient revenue, and other sources; and including documentation that the organization is tax-exempt. Deadline for submission is December 31, 1992. Send submissions to Ms. Remie Cannon, scholarship staff coordinator, American College of Physician Executives, 4890 W. Kennedy Blvd., Suite 200, Tampa, FL 33609-2575. For more information, contact Ms. Remie Cannon at 1-800-562-8088. ■

Welcome!

The Medical and Chirurgical Faculty of Maryland welcomes the new members listed below. They join an organization with a 193-year history of dedicated service to improving the health and welfare of the people of Maryland. With the help and expertise of longtime members and the participation and input of new members, Med Chi can continue its proud tradition of ensuring quality health care.

ALLEGANY COUNTY

Hasslinger, Brian J.
P.O. Box 1689
Cumberland, MD 21502
(310) 777-4851
OTO; SS 125

Aronson, Daniel
Greater Baltimore Medical Center
Dept. of Radiology
Baltimore, MD 21204
(410) 828-2320
DR; BC 080; SS 912,588,324

Haskel, Ethan J.
9101 Franklin Square Drive
Suite 214
Baltimore, MD 21237
(410) 574-1330
CDS; BC 020,201

ANNE ARUNDEL COUNTY

De Borja, Christopher L.
3708 Mountain Road
Pasadena, MD 21122
(410) 255-1600
IM; SS 312

Breitman, Sara L.
6525 N. Charles Street
Suite 134
Towson, MD 21204
(410) 828-4804
P; BC 075; SS 516

Hicks, Charles W., III
8831 Satyr Hill Road
Suite 211
Baltimore, MD 21234
(410) 661-9250
P; BC 075; SS 516

Farrell, Katherine P.
Anne Arundel County Health
Department
3 Harry S. Truman Parkway
Annapolis, MD 21401
(410) 222-7252
PH,GPM; SS 430

Burk, Cheryl D.
302 Greenspring Station
Lutherville, MD 21093
(410) 825-5200
IM; SS 654,312

Holloway, Anita M.
3901 Greenspring Avenue
Baltimore, MD 21211
(410) 669-2650
PM; BC 060; SS 144

Perez-Alard, Jorge L.
3708 Mountain Road
Pasadena, MD 21122
(410) 255-1600
IM; SS 312

Dunsmore, Nathan A.
6701 N. Charles Street
Towson, MD 21204
(410) 828-2704
PTH; SS 828

Houk, Theodore C.
7825 York Road
Towson, MD 21204
(410) 296-5200
IM

BALTIMORE COUNTY

Akar, Ahmad A.
5401 Old Court Road
Suite 201
Randallstown, MD 21133
(410) 521-1900
GS; BC 085

Fedder, Ira L.
7505 Osler Drive
Suite 104
Towson, MD 21204
(410) 337-8888
ORS; SS 120

Jacob, Stephen P.
GBMC
Dept. of Anesthesiology
6701 N. Charles Street
Baltimore, MD 21204
(410) 828-2203
AN; BC 005; SS 636

Ammlung, Robert C.
516 N. Rolling Road
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Catonsville, MD 21228
(410) 788-7030
IM; BC 020; SS 312

Gichtin, David C.
9101 Franklin Square Drive
Suite 313
Baltimore, MD 21237
(410) 574-5222
AN; SS 636

Khan, Agha S.
2435 West Belvedere Avenue
Suite 26
Baltimore, MD 21215
(410) 578-8314
NS

Goins, Martin A., III
2411 W. Belvedere Avenue
Baltimore, MD 21215
(410) 578-5175
OTO; BC 045; SS 125

Magat, Aaron H.
23 Crossroads Drive
Suite 215
Owings Mills, MD 21117
(410) 363-9400
OBG; SS 300

Pichney, Lisa S.
7505 Osler Drive
Suite 307
Towson, MD 21204
(410) 296-4210
GE; BC 020; SS 312,384,615,288

Preysner, Linda A.
11 Slade Avenue, #104
Pikesville, MD 21208
(410) 486-6425
IM; BC 020; SS 654

Reichman, Wayne
2112 Belair Road
Suite 1
Fallston, MD 21047
(410) 879-2006
VS; BC 085

Rizzuto, Charles
7401 Osler Drive
Basement
Towson, MD 21204
(410) 828-5863
AN; SS 636

Yevak, Richard J., Jr.
Physicians Anesthesia Assoc., PA
6701 N. Charles Street
Baltimore, MD 21204
(410) 296-4616
AN; BC 005

BALTIMORE CITY

Apollon, Gerald
6303 Roan Stallion Lane
Columbia, MD 20145
(410) 796-8257
FP,EM; SS 060

Chouvalit, A.C.
100 North Broadway
Baltimore, MD 21231
(410) 522-8569
IM; BC 020

Kahntroff, Bridget C.
100 North Broadway
Church Hospital Lab
Baltimore, MD 21231
(410) 522-8550
PTH; BC 050; SS 648,828

Levy, Bernard A.
(ASSOCIATE)
666 W. Baltimore Street
Baltimore, MD 21201
(410) 328-7936

Mc Catty, Sandra L.
900 S. Caton Avenue
Dept. of Emergency Medicine
Baltimore, MD 21229
(410) 368-2000
EM; BC 016; SS 285

Ordman, Joan
222 W. Cold Spring Lane
Baltimore, MD 21210
(410) 889-1801
IM

Patt, Philip G.
Sinai Hospital
Dept. of Radiology
Belvedere at Greenspring Avenue
Baltimore, MD 21215
(410) 578-5325
R; BC 080; SS 912,324

Roche, Jeffrey C.
100 North Broadway
Baltimore, MD 21231
(410) 522-8552
PTH; BC 050; SS 828

Valentine, Martin D.
5501 Hopkins Bayview Circle
Baltimore, MD 21224
(410) 550-2108
IM,AI; BC 020,003; SS 036,495,696,902

CARROLL COUNTY

Ballas, Christos M.
224 Washington Heights
Medical Center
Westminster, MD 21157
(410) 876-7000
OBG; SS 300

CHARLES COUNTY

Akthar, Waheed U.
P.O. Box 1737
White Plains, MD 20695
(301) 934-9300
IM; BC 020; SS 312,285

Davison, Robert L., Jr.
Pembroke Square
Suite 104
Waldorf, MD 20601
(301) 645-4220
IM; SS 312

Dumalag, Lucy B.
P.O. Box 1737
White Plains, MD 20695
(301) 934-9300
IM

Kidder, Robert E.
Physicians Memorial Hospital
Dept. of Imaging
La Plata, MD 20646
(301) 645-0170
DR; BC 080; SS 324,912

HARFORD COUNTY

Biondo, Thomas A.
319 S. Union Avenue
Union Medical Clinic
Havre de Grace, MD 21078
(410) 939-4477
IM; SS 312

Patanaphan, Vinita
1200 Brass Mill Road
Belcamp, MD 21017
(410) 272-9224
RO; BC 804; SS 324,675,590,564

HOWARD COUNTY

Hammond, Nancy M.
5999 Harpers Farm Road
W-200
Columbia, MD 21044
(410) 997-8494
OBG; SS 300

Henderson, Anita L.
11055 Little Patuxent Parkway
Suite 203
Columbia, MD 21044
(410) 997-6991
D; BC 015; SS 048

Herman, Robert S.
(ASSOCIATE)
6976 Newberry Drive
Columbia, MD 21044
(410) 531-6984
AN; BC 005; SS 636

Qaiyumi, Waheeda S.
9650 Santiago Road
Suite 110
Columbia, MD 21045
(410) 992-7002
PD

Schub, Russell O.
5999 Harpers Farm Road
Suite 215E
Columbia, MD 21044
(410) 730-1000
GE; BC 020,203; SS 312,288,384

Silber, Glenn M.
4801 Dorsey Hall Drive
Suite 204
Ellicott City, MD 21042
(410) 730-6000
AI; BC 003,055; SS 036,252

KENT COUNTY

Noble, Helen A.
Kent & Queen Anne's Medical
Office Building
Chestertown, MD 21620
(410) 778-0200
IM; BC 020; SS 312,654

MONTGOMERY COUNTY

Bernstein, Wayne I.
11105 Stillwater Avenue
Kensington, MD 20895
(301) 949-1238
OBG

Chazin, Howard D.
5530 Wisconsin Avenue
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Chevy Chase, MD 20815
(301) 718-1885
N

Chu, Robert H.
5515 Randolph Road
Rockville, MD 20852
(301) 989-9132
OPH; SS 115

Frost, Mitchell M.
5622 Shields Drive
Bethesda, MD 20817
(301) 493-9400
GS; SS 336

Giblin, Walter J.
9800 Falls Road
Potomac, MD 20854
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U; BC 095

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DIRECTORY CHANGES

The Med Chi membership directory is published annually. It lists, by county, the addresses, phone numbers, specialties, board certifications, and specialty society affiliations of all Med Chi members. This update provides the most recent changes.

ALLEGANY COUNTY

Lewis, Thomas F.
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Yin, Robert
BC 203, 213

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*Please send address and
telephone number changes
to Wanda Griebel,
Membership Services,
Med Chi, 1211 Cathedral
St., Baltimore, MD 21201
or call 410-539-0872 or
800-492-1056. Copies of
The 1992-93 Membership
Directory and Allied
Health Listing may be
purchased for \$85.00 plus
postage and handling.*

The Maryland Medical Journal (MMJ) is a monthly publication of the Medical and Chirurgial Faculty of Maryland. The journal's goals are educational and informative: the publishing of scientific articles (original research, case studies, and review articles) and other technical information, as well as editorials, letters, special articles (evaluations, position papers, reviews of nonscientific subjects),

Information for AUTHORS

membership and legislative news, continuing medical education notices, and programs and policies of the faculty.

- **Letter of transmittal**—The letter of transmittal, which all authors must sign, should include the full names, degrees, titles, and affiliations of all authors, and the name, address, and phone number of the author to whom reprint requests and correspondence should be sent.

The letter should include a statement to the effect that all authors have participated in the conception and design of the work and in the writing of the manuscript, and that they take public responsibility for it. The authors should attest to the validity and legitimacy of the data, and acknowledge that they have reviewed the final version of the manuscript and approve it for publication.

In addition, the letter must include a paragraph that transfers copyright ownership to the *MMJ* in the event that the work is published.

- **Manuscript preparation**—Manuscripts should be submitted to Editor, *MMJ*, 1211 Cathedral Street, Baltimore, MD 21201-5585. Manuscripts must be original material not previously published and not under consideration by another publication. A synopsis/abstract of 30 to 50 words (maximum) is required.

All material, including references, tables, and legends, must be double-spaced. Pages should be numbered. (All abbreviations should be spelled out on first use.) The original manuscript plus one copy should be submitted on standard (8.5" x 11") bond paper. If at all possible, an IBM-compatible disk should be included, with the manuscript entered in a WordPerfect, Multimate, Wordstar, or ASCII format; the transmittal letter should identify the format used.

- **References**—References are limited to those citations noted in the text. References should be numbered consecutively as they appear in the text and should be kept to a minimum (fewer than thirty-five). Personal communications and unpublished data are not acceptable. At a minimum, references should include names of all authors, complete title of the article cited, name of journal abbreviated according to *Index Medicus* (if abbreviation is not known, journal name should be spelled out fully), year of publication, volume number, and first and last page numbers. Sample references are as follows:

1. Stevens MB. The clinical spectrum of SLE. *Md Med J* 1991; 10:875-85.

2. Ropes MW. Characteristics, manifestations, and pathologic findings. In: Ropes MD, ed. *Systemic Lupus Erythematosus*. Cambridge, MA: Harvard University Press. 1976; 50-4.

- **Tables**—Tables should be typed on separate sheets of paper, be numbered, and have a brief descriptive title. Data presented in tables should be self-explanatory and should supplement, not duplicate, the text; the Editor reserves the right to edit tables. Authors should be sure that statistics are consistent in both tables and text.

- **Illustrations**—Illustrations include material that cannot be set in type. Photographic material must be submitted as high-contrast, glossy prints. Drawings and graphs must be done professionally in india ink on high-grade white drawing paper or be computer generated. Identification—including figure number, the title of manuscript, the name of corresponding author, and arrow indicating top—should be typed on a gummed label and affixed to the back

Checklist

- ☐ Original manuscript and one copy.
- ☐ IBM-compatible disk in WordPerfect, Multimate, Wordstar, or ASCII.
- ☐ Everything double-spaced.
- ☐ Letter of transmittal, signed by all authors, that includes release of copyright, statement of authorship responsibility, title and affiliation of all authors, and identification and phone number of corresponding author.
- ☐ Thirty to fifty word synopsis.
- ☐ Permission-to-borrow letters for any previously published illustrations or tables.

of each illustration. Legends for illustrations should be typed on a separate page with numbers corresponding to those on the photographs or drawings. Recognizable photographs of patients are to be masked and should carry with them written permission for publication. Cost of printing color photographs must be borne by the author.

- **Permissions**—Material taken from other sources must be accompanied by written permission from both author(s) and publisher allowing the *MMJ* to reproduce the information/figure.

- **Editorial responsibility**—All manuscripts are acknowledged upon receipt. They are subject to peer review by an editorial board and, at times, by guest reviewers in appropriate fields of medicine, to determine the originality, validity, and importance of the content and conclusions. Authors are usually notified of the status of their papers (acceptance, revision, or rejection) within 4 to 8 weeks of receipt; however, longer delays are sometimes unavoidable. Reviewers' comments will be returned with rejected manuscripts at the discretion of the Editor. All guest reviewers will remain anonymous.

Accepted manuscripts become the permanent property of the *MMJ* and are subject to copy editing. (The *Chicago Manual of Style* and the unabridged *Random House Dictionary of the English Language* are used as style guides.) The corresponding author is sent a reprint order form and galley proofs. S(he) then has 48 hours in which to make minor changes and clear all corrections and changes with co-authors; if proofs are not returned by the specified date, they will be considered approved as typeset. ■

The Johns Hopkins Medical Institutions

All courses at the Turner Auditorium unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Education, 720 Rutland Ave., Baltimore, MD 21205 (410-955-2959).

- | | |
|---|-------------------------|
| Advanced pediatric life support courses. 20 Cat 1 AMA/PRA credits. Fee: TBA. | Nov. 2-4 |
| Progress in pediatrics. 11 Cat 1 AMA/PRA credits. Fee: \$140 physicians; \$80 residents, fellows, and nurse practitioners. | Nov. 6-7 |
| Horizons in transplantation. 6.5 Cat 1 AMA/PRA credits. Fee: \$45. | Nov. 13 |
| Neural mechanisms of the auditory and vestibular systems II. Cat 1 AMA/PRA credits available. Fee: \$375 physicians; \$300 residents and fellows; \$450 allied health professionals. | Dec. 1-2 |
| Clinical management of vestibular disorders. Cat 1 AMA/PRA credits available. Fee: \$375 physicians; \$300 residents and fellows; \$450 allied health professionals. | Dec. 3-4 |
| Current concepts in lipidology and atherosclerosis, at the Sheraton Inner Harbor Hotel, Baltimore, MD. 8.5 Cat 1 AMA/PRA; 8 AAFP prescribed hours. Fee: \$100 physicians; \$75 residents, fellows, and allied health professionals. | Dec. 4 |
| The Wilmer Ophthalmological Institute's current concepts in ophthalmology. 20 Cat 1 AMA/PRA credits. Fee: \$300 physicians; \$250 residents, fellows, and allied health professionals. | Dec. 10-12 |
| Third annual neurology conference for the primary practitioner, at the Harbor Court Hotel, Baltimore, MD. 6 Cat 1 AMA/PRA credits available. Fee: \$125 physicians; \$75 residents, fellows, and allied health professionals. | Dec. 12 |
| Endoscopic sinus surgery. 19 Cat 1 AMA/PRA credits for lab and lectures; 14.5 Cat 1 AMA/PRA credits for lecture only. Fee: \$1,250 for laboratory and lectures; \$295 for lecture series only. | Jan. 7-8, 1993 |
| Advanced endoscopic sinus surgery. 9 Cat 1 AMA/PRA credits. Fee: \$1,050. | Jan. 9, 1993 |
| 1993 update in the management of age-related macular degeneration. 6.5 Cat 1 AMA/PRA credits for one-day course; 8.5 Cat 1 AMA/PRA credits for two-day course. Fee: \$200 physicians; \$100 residents, fellows, and allied health professionals; \$350 lectures and optional lab course. | Jan. 22-23, 1993 |
| Americans with disabilities act of 1992 and you. Info: Dr. Jacqueline K. Corn, 410-955-2609 | Jan. 29-30, 1993 |
| PET and SPECT imaging of living brain chemistry. 18 Cat 1 AMA/PRA credits. Fee: \$495 physicians; \$395 residents, fellows, and allied health professionals. Info: Patty Campbell, 410-955-6046 or Julia Buchanan, 410-955-8582. | Mar. 10-12, 1993 |
| Spectrum of developmental disabilities XV: PL 94-142; PL 99-457—Issues of concern. 20 Cat 1 AMA/PRA. Fee: \$425. | Mar. 15-17, 1993 |
| 34th annual postgraduate institute for pathologists in clinical cytopathology. Course A: Home study, March-April 1993. Course B: Lecture series with laboratory studies. 140 Cat 1 AMA/PRA credits. | Apr. 19-30, 1993 |
| Principles and practice of clinical MRI, at the Stouffer Harborplace Hotel, Baltimore, MD. Cat 1 AMA/PRA credits available. Fee: TBA. | Apr. 22-25, 1993 |
| XII international papillomavirus workshop, at the Hyatt Regency Hotel, Baltimore, MD. 30 Cat 1 AMA/PRA credits. Fee: \$400 prior to June 30, 1993; \$450 after June 30, 1993. Info: Gretchen Shelton, 410-931-8108. | |

Continuously throughout the year

Visiting preceptorship in pediatric critical care medicine. Ongoing five-day preceptorship by appointment. 40 Cat 1 AMA/PRA credits. Fee: \$600.

The department of radiology and radiological sciences offers several courses in abdominal and obstetrical ultrasound. Info: P. Williams, 410-955-3169.

Visiting physicians. Offered throughout the year for experience in the lab and participation in read-in sessions; by appointment only. 40 Cat 1 AMA/PRA credits. Fee: \$500.

Johns Hopkins medical grand rounds. Accredited audiovisual continuing education series of case discussions for clinicians; thirty topics per year in five bimonthly programs. Individual and group subscriptions. 40 Cat 1 AMA/PRA credits. Info: 410-955-3988.



PHYSICIAN'S RECOGNITION AWARD

During October 1992, the physicians listed below received the American Medical Association's (AMA's) Physician's Recognition Award. Established in 1968, the award's purpose is to encourage physician participation in continuing medical education and to recognize those physicians who have voluntarily completed programs of continuing medical education.

Albert Michael Antlitz
Mercedita S. Conanan
Albert H. Dudley
James D. Felsen
Arnaldo Antonio Garro
Nader M. Habashi
Todd David Heller
Noel Scott Howard

Michael Elihu Klein
Robert Beck Kroopnick
Jack Kushner
Ann E. Lewandowski
Manfred W. Lichtmann
Edward Louis Morris
William Glenn Prescott
Glendon Ennes Rayson

Robert Alan Shaw
Albert John Strauss
Richard Leslie Taylor
Jonathan Richard Walburn
William Craig Wessells
Charles Austin Wintemitz
Erwin Witkin

University of Maryland

For each course, additional information may be obtained by contacting the Program of Continuing Education, University of Maryland School of Medicine, Room 14-011, BRB, 655 W. Baltimore St., Baltimore, MD 21201 (410-328-3956) or by calling the phone number listed after a specific program. FAX 410-328-3103.

- Infectious disease update: Diagnosis and treatment of commonly acquired infections**, at the Sheraton Hagerstown Conference Center, Hagerstown, MD. 6 Cat 1 AMA/PRA credits. Nov. 5
Fee: \$25.
- Epilepsy today and tomorrow: What, why, when, and how**, at the Harbor Court Hotel, Baltimore, MD. 5 Cat 1 AMA/PRA credits. Fee: \$65. Info: Diana Roche, 410-242-7300. Nov. 13
- HIV Advanced Counseling Skills II**, sponsored by the Maryland AIDS Professional Education Center, in Hagerstown, MD. Info: Gwen Kergides, 410-328-8639. Nov. 19-20
- The Maurice C. Pincoffs lecture in medicine**, in Davidge Hall, UMAB campus. 1 Cat 1 AMA/PRA credit. Fee: none. Info: Theodore E. Woodward, M.D., 410-328-6070. Dec. 7
- HIV Counseling Skills I**, sponsored by the Maryland AIDS Professional Education Center, in Baltimore, MD. Info: Gwen Kergides, 410-328-8639. Dec. 8-11
- Advanced trauma life support**, sponsored by the Maryland Institute for Emergency Medical Services Systems, in Baltimore, MD. Info: Office of International Development, 410-328-2399. Mar. 10-11, 1993
- Managed care and quality improvement: Making a difference**, sponsored by the Maryland Institute for Emergency Medical Services Systems, in Baltimore, MD. Info: Office of International Development, 410-328-2399. Mar. 11, 1993
- Alcohol and trauma care**, sponsored by the Maryland Institute for Emergency Medical Services Systems, in Baltimore, MD. Info: Office of International Development, 410-328-2399. Mar. 11, 1993
- R. Adams Cowley 15th national trauma symposium**, sponsored by the Maryland Institute for Emergency Medical Services Systems, at the Hyatt Regency Baltimore, in Baltimore, MD. Info: Office of International Development, 410-328-2399. Mar. 12-14, 1993

Continuously throughout the year

- Visiting professor program.** A directory of speakers and their topics is available to area hospitals and other health care organizations. NO administrative fees are charged for this service. Info: 410-328-3956.
- Visiting fellowship in interventional radiology.** Five-day practicum for radiologists, including conferences, patient rounds, and laboratory observations. By appointment only. 40 Cat 1 AMA/PRA credit. Fee: \$1,200.
- Ultrasound: Preceptorships.** For physicians or sonographers with six-months' experience in practicing ultrasound. By appointment only. 40 Cat 1 AMA/PRA credit. \$500.
- Departmental rounds and conferences.** Weekly, hands-on, and lecture presentations hosted by the university's clinical departments. Hour-for-hour Cat 1 AMA/PRA credits available. Brochure available.
- Pediatric grand rounds.** Every Thursday from September to June, except third Thursday, in the R. Adams Cowley Shock Trauma Auditorium. Info: Bonnie Winters, 410-328-6777.

Miscellaneous meetings

- | | |
|---|-------------------------|
| President's eastern regional conference , sponsored by the Medical and Chirurgical Faculty of Maryland, at the Cambridge Yacht Club, Cambridge, MD. 1 Cat 1 AMA/PRA credits. Fee: none. Info: Joan Mannion, 410-539-0872 or 1-800-492-1056. | Nov. 5 |
| The African-American perspective on substance abuse , sponsored by the Monumental City Medical Society, the Baltimore City Health Department, and the Baltimore Substance Abuse Systems, Inc., at the Stouffer Harborplace Hotel, Baltimore, MD. 7 Cat 1 AMA/PRA credits. Fee: \$75. Info: 410-396-1589. | Nov. 7 |
| Sixteenth annual symposium on computer applications in medical care , sponsored by the American Medical Informatics Association, at the Baltimore Convention Center, Baltimore, MD. Fee: \$505. | Nov. 8-11 |
| International standards update , sponsored by the Association for the Advancement of Medical Instrumentation, in Washington, DC. Info: 703-525-4890, ext. 212 or 210. | Nov. 10 |
| Arthritis care for the 1990s: A practical approach for the primary care physician , sponsored by the Arthritis Foundation, Maryland Chapter, at the Sheraton Inner Harbor Hotel, Baltimore, MD. 5 Cat 1 AMA/PRA credits. Fee: \$45, \$30 if not requesting CME. Info: Karen Krug, 561-8090 or 800-365-3811. | Nov. 14 |
| Third annual conference on addiction: Physician health and education , sponsored by the Medical and Chirurgical Faculty of Maryland, at the Faculty Building, Baltimore, MD. 7.5 Cat 1 AMA/PRA credits. Fee: \$50 Med Chi members; \$100 physician nonmembers and PhDs; \$25 allied health professionals; No charge for students and residents. Info: Vivian Smith, 410-539-0872 or 1-800-492-1056. | Nov. 21 |
| Williamsburg conference on heart disease , sponsored by the American College of Cardiology at the Williamsburg Conference Center, Williamsburg, VA. 18 Cat 1 AMA/PRA credits. Info: 800-257-4739. | Dec. 6-9 |
| Cardiovascular science and technology conference , sponsored by Association for the Advancement of Medical Instrumentation, Washington, DC. Info: 703-525-4890, ext. 210 or 212. | Dec. 12-14 |
| Maryland Academy of Family Physicians first semiannual meeting , at Hyatt Regency Inner Harbor Hotel, Baltimore, MD. 10 Cat 1 AMA/PRA credits; 10 AAFP prescribed hours. Fee: \$100 MAFP members; \$150 nonmembers; \$60 paramedicals; No charge for residents, medical students, and MAFP life and retired members. Info: William P. Jones, M.D., 410-747-1980. | Jan. 30-31, 1993 |
| Cardiovascular conference at Snowshoe , sponsored by the American College of Cardiology, at the Mountain Lodge Conference Center, Snowshoe, WV. 13.5 Cat 1 AMA/PRA. Info: 1-800-257-4739. | Feb. 1-3, 1993 |
| 195th annual meeting of the Medical and Chirurgical Faculty of Maryland , at the University of Maryland Center of Adult Education, College Park, MD. Info: Betsy Newman, 410-539-0872 or 1-800-492-1056. | April 30-May 1 |
| Virginia Society of Otolaryngology-HNS annual meeting , at the Tides Inn Resort, Irvington, Virginia. Info: Donna Scott, 804-353-2721. | May 7-8, 1993 |
| Maryland Academy of Family Physicians 45th annual meeting and scientific session , at the Sheraton Ocean City Resort and Conference Center, Ocean City, MD. 30.75 AMA/PRA Cat 1 credits; 30.75 AAFP prescribed hours. Fee: \$240 members; \$275 non-members; 135 paramedicals; No charge for residents, medical students, MAFP retired and life members. Info: Francis C. Bruno, M.D., 410-747-1980. | May 12-16, 1993 |
| 6th annual trauma anesthesia and critical care symposium , sponsored by the International Trauma Anesthesia and Critical Care Society (ITACCS) and Multinational Academic Consortium, at the Hyatt Regency, Baltimore, MD. Info: Kimberly C.A. Unitas, 410-328-2399. | May 20-22, 1993 |

Virginia Society of Ophthalmology annual meeting, at the Norfolk Marriott Waterside, Norfolk, May 21-22, 1993
VA. Info: Donna Scott, 804-353-2721.

Continuously throughout the year

Fluorescein angiography conference, sponsored by the Retina Center, St. Joseph Hospital, Baltimore, MD, first and third Mondays of each month; 8:00-9:00 a.m. Fee: none. Info: R. Classon, 410-337-4500.

Shady Grove Adventist Hospital,

9901 Medical Center Drive, Rockville, MD. Info: 301-279-6115.

Risk management.

Nov. 5

Diabetes.

Nov. 12

CME LECTURERS NEEDED IN THE VIRGIN ISLANDS

The U.S. Virgin Islands has a very small medical society (VIMS) with only two continuing medical education (CME) sponsors: the St. Croix Hospital and the St. Thomas Hospital. Both hospitals have well-organized, active CME committees, but both have difficulty obtaining qualified speakers for CME programs.

Although VIMS cannot afford to offer stipends, travel expenses, or lodging, it would appreciate having qualified physicians—who choose to vacation in the Virgin Islands—provide a CME lecture as per ACCME provisions.

Interested physicians are encouraged to call Dr. Angelo Galiber, St. Croix Hospital Staff CME director, at 809-778-5305; Dr. Brian Cheetham, St. Thomas Hospital CME chairperson, at 809-774-0506; or Dr. Francis J. Farrell, VIMS Accreditation Committee chairperson, at 809-778-6400 or 809-776-0506.

Opening Doors to Physician Health

International Conference on Physician Health

January 28-31, 1993
Marriott Mountain Shadows Resort
Scottsdale, Arizona

*Sponsored by the American Medical Association,
the Canadian Medical Association,
the Federation of State Medical Boards,
and the Federation of Medical Licensing
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HIV infection and AIDS ... the rights of the disabled ... substance abuse ... mental illness ... aging. These health problems are on our minds and in our news, affecting the way we live, the way we interact, the way we plan for our futures.

And physicians are not immune to them.

Now you can discover more about how physicians are facing their own health challenges—at the premier meeting on physician health concerns, the *International Conference on Physician Health*.

The conference provides an opportunity to hear about the latest research findings on physician health, as well as new and innovative treatment and education programs in the area. Topics will include:

- Health maintenance and promotion for physicians
- Cocaine-sensitive DNA

- Mental illness in physicians
- Physicians with physical limitations
- HIV infection among physicians

While you explore the issues, take advantage of the Mountain Shadows Resort location for a personal health break. Golf, play tennis, swim, hike in the mountains—or join the stress-reduction exercise classes.

To qualify for special “early bird” registration rate, complete the coupon below and return before December 11.

American Medical Association

Physicians Health Foundation

Caring for the Caregiver



Yes, register me ...

for the 1993 *International Conference on Physician Health*,
January 28-31, Marriott Mountain Shadows Resort,
Scottsdale, Arizona.

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Title _____

Organization _____

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City _____ State _____ Zip _____

Mail this form to: International Conference on Physician Health, American Medical Association, 515 North State Street, Chicago, IL 60610, or call 800 262-3211.

Registration Fees (US dollars)	“Early Bird”	After 12/11/92
AMA members, physicians outside the US	\$295	\$345
Nonmembers	\$350	\$400
Residents	\$195	\$245
Students	\$175	\$175

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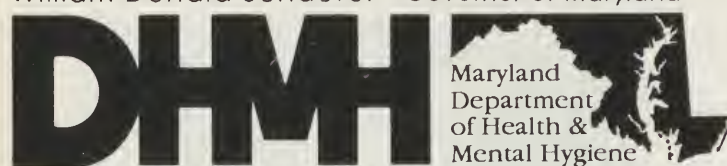
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Department of Health & Mental Hygiene

J. Mehnen Joseph, PhD - Director
Community Health Surveillance & Laboratories Admin.

Ebenezer Israel, MD, MPH - Director
Epidemiology & Disease Control Program

November, 1992

Prevention and Control of Influenza

Influenza in Maryland 1991 - 1992

Fifty-three influenza A isolates were reported during the 1991-92 season; no influenza B was reported. Forty (91%) of the 44 isolates subtyped by the Department of Health and Mental Hygiene Virology Laboratory were antigenically related to influenza A/Beijing/353/89, the A(H3N2) component included in the 1991-92 influenza vaccine, and four (9%) were related to A/Taiwan/1/86, the A(H1N1) component of the vaccine.

Maryland had 10 outbreaks of culture confirmed influenza A and 30 outbreaks of influenza-like illness (ILI), all of which occurred in long term care or institutional facilities. Most of the outbreaks occurred from late December through January (see Figure 1). Forty-five hospitalizations and 18 deaths occurred in the 10 confirmed influenza outbreaks versus 18 hospitalizations and five deaths in the 30 ILI outbreaks.

Two measures available in the U.S. that can reduce the impact of influenza are immunoprophylaxis with inactivated (killed-virus) vaccine and chemoprophylaxis or therapy with an influenza-specific antiviral drug (e.g., amantadine). Vaccination of high-risk persons each year before the influenza season is currently the most effective

measure for reducing the impact of influenza. Because the antigens included in the 1992-1993 vaccine differ from the 1991-1992 vaccine, and because the immunity for an individual declines in the year following vaccination, only the 1992-1993 vaccine should be used to provide protection for the upcoming influenza season.

ACIP RECOMMENDATIONS

The following Immunization Practices Advisory Committee (ACIP) recommendations have been condensed from the CDC. *MMWR* 1992; 41 (no. RR-9): 1-17. The primary changes from the 1991 recommendations include statements about the influenza strains in the trivalent vaccine for 1992-1993, the vaccination of persons with known hypersensitivity to eggs or other components of the influenza vaccine, and the optimal timing of influenza vaccination.

I. RECOMMENDATIONS FOR THE USE OF INFLUENZA VACCINE

The trivalent vaccine prepared for the 1992-1993 season includes A/Texas/36/91-like (H1N1), A/Beijing/353/89-like (H3N2), and B/Panama/45/90-like hemagglutinin antigens. Recommended doses are listed in Table 1.

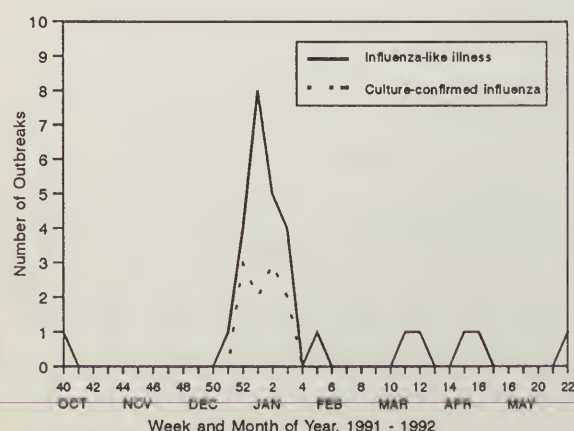
Target Groups for Special Vaccination Programs

To maximize protection of high-risk persons, they and their close contacts should be targeted for organized vaccination programs. The optimal time for vaccination campaigns is from mid-October to mid-November.

Groups at Increased Risk for Influenza-Related Complications

1. Persons ≥ 65 years of age.
2. Residents of nursing homes and other chronic-care facilities housing persons of any age with chronic medical conditions.
3. Adults and children with chronic disorders of the pulmonary or cardiovascular systems, including children with asthma.

FIGURE 1. Nursing Home and Institutional Outbreaks of Influenza and Influenza-like Illness



IMPORTANT INFORMATION ABOUT INFLUENZA AND INFLUENZA VACCINE, (1992-1993)

Please read this carefully

**Influenza
7/1/92**

WHAT IS INFLUENZA ("FLU")?

Influenza (or "flu") is a viral infection of the nose, throat, bronchial tubes, and lungs that can make someone of any age ill. Usually the flu occurs in the United States from about November to April. If you get the flu, you usually have fever, chills, cough, and soreness and aching in your back, arms, and legs. Although most people are ill for only a few days, some persons have a much more serious illness and may need to go to the hospital. On average, thousands of people die each year in the United States from the flu or related complications.

WHO SHOULD GET INFLUENZA VACCINE?

Because influenza is usually not life threatening in healthy individuals and most people recover fully, health officials emphasize the use of vaccine for the elderly and people with other health problems which make these individuals more likely to be seriously ill or to die from the flu or its complications. For example, people who after even light exercise become short of breath due to diseases affecting their heart or lungs, and people who have low resistance to infections, are likely to be more seriously affected by the flu. Thus, the following groups are at increased risk for serious illness with the flu and should receive vaccine:

- All people 65 years of age or older.
- Adults and children with long-term heart or lung problems which caused them to see a doctor regularly, or to be admitted to a hospital for care during the past year.
- Residents of nursing homes, and other institutions housing patients of any age who have serious long-term health problems.
- People of any age who during the past year have regularly seen a doctor or have been admitted to a hospital for

treatment for kidney disease, cystic fibrosis, chronic metabolic diseases such as diabetes, anemia ("low blood"), or severe asthma.

- People who have a type of cancer or immunological disorder (or use certain types of medicines) that lowers the body's normal resistance to infections. (Because influenza might cause serious illness and complications in persons infected with the HIV virus which causes AIDS, these individuals should receive influenza vaccine.)
- Children and teenagers (6 months through 18 years of age) on long-term treatment with aspirin who, if they catch the flu, may be at risk of getting Reye syndrome (a childhood disease that causes coma, liver damage, and death).

Medical staff who provide care to high-risk patients in health-care facilities should be vaccinated, to reduce the possibility that these patients might catch the flu when receiving medical care. Family members or others who provide care to high-risk persons at home should also be vaccinated. The possibility for spreading the flu to high-risk persons can be reduced by vaccinating:

- Doctors, nurses, and others in both hospital and outpatient-care settings who have contact with high-risk patients in all age groups, including children.
- Personnel of nursing homes and chronic-care facilities who have contact with patients or residents.
- Individuals who provide care to high-risk persons at home, such as visiting nurses and volunteers, as well as all household members, including children, whether or not they are providers of care.

In addition, a flu shot may be given to:

- Persons wishing to reduce their chances of catching the flu.
- Persons who provide essential community services.

(PLEASE READ OTHER SIDE)

4. Adults and children who have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medications).

5. Children and teenagers (6 months-18 years of age) who are receiving long-term aspirin therapy, and therefore may be at risk of developing Reye syndrome after influenza.

Groups That Can Transmit Influenza to High-Risk Persons

1. Physicians, nurses, and other personnel in both hospital and outpatient-care settings who have contact with high-risk persons among all age groups, including infants.
2. Employees of nursing homes and chronic-care facilities who have contact with patients or residents.
3. Providers of home care to high-risk persons (e.g., visiting nurses, volunteer workers).
4. Household members (including children) of high-risk persons.

Persons Who Should Not Be Vaccinated

Inactivated influenza vaccine should not be administered to persons known to have anaphylactic hypersensitivity to eggs or to other components of the influenza vaccine without first consulting a physician. Allergy evaluation and desensitization may be considered.

Persons with acute febrile illnesses usually should not be vaccinated until their symptoms have abated.

Simultaneous Administration of Other Vaccines, Including Childhood Vaccines

The target groups for influenza and pneumococcal vaccination overlap considerably. Both vaccines can be administered at the same time at different sites without increasing side effects. However, influenza vaccine must be administered each year, whereas pneumococcal vaccine is generally administered only once to all but those at highest risk of fatal pneumococcal disease.

Children at high risk for influenza-related complications may receive influenza vaccine at the same time as measles-mumps-rubella, *Haemophilus b*, pneumococcal, and oral polio vaccines. Vaccines should be administered at different sites on the body. Influenza vac-

TABLE 1. Influenza vaccine* dosage, by age group — United States, 1992-93 season

Age group	Product†	Dosage	No. doses	Route‡
6-35 mos.	Split virus only	0.25 mL	1 or 2‡	IM
3-8 yrs.	Split virus only	0.50 mL	1 or 2‡	IM
9-12 yrs.	Split virus only	0.50 mL	1	IM
>12 yrs.	Whole or split virus	0.50 mL	1	IM

*Contains 15 µg each of A/Texas/36/91-like (H1N1), A/Beijing/353/89-like (H3N2), and B/Panama/45/90-like hemagglutinin antigens in each 0.5 mL. Manufacturers include: Connaught Laboratories, Inc. (distributed by E.R. Squibb & Sons, Inc.) (Fluzone® whole or split); Evans Medical Ltd.-Lederle Laboratories (distributed by Lederle Laboratories) (Flu-Imune® purified surface antigen vaccine); Parke-Davis (Fluogen® split); and Wyeth-Ayerst Laboratories (Influenza Virus Vaccine, Trivalent® split). For further product information call Connaught, (800) 822-2463; Lederle, (800) 533-3753; Parke-Davis, (800) 223-0432; Wyeth-Ayerst, (800) 950-5099.

†Because of the lower potential for causing febrile reactions, only split-virus vaccines should be used among children. They may be labeled as "split," "subvirion," or "purified-surface-antigen" vaccine. Immunogenicity and side effects of split- and whole-virus vaccines are similar among adults when vaccines are administered at the recommended dosage.

‡The recommended site of vaccination is the deltoid muscle for adults and older children. The preferred site for infants and young children is the anterolateral aspect of the thigh.

§Two doses administered at least 1 month apart are recommended for children <9 years of age who are receiving influenza vaccine for the first time.

cine should not be given within 3 days of vaccination with pertussis vaccine.

II. RECOMMENDATIONS FOR THE USE OF AMANTADINE

As with all drugs, symptoms may occur that are side effects of amantadine among a small population of persons. Such symptoms are rarely severe, but may be important for some categories of patients.

Amantadine is recommended for:

Outbreak Control in Institutions

When used for outbreak control, amantadine should be administered to all residents of the affected institution, vaccinated or not, and to unvaccinated staff who provide patient care.

Use as Prophylaxis

- High-risk individuals vaccinated after influenza A activity has begun
- Persons providing care to high-risk persons
- Immunodeficient persons
- Persons for whom influenza vaccine is contraindicated
- Others who wish to avoid influenza A illness.

Use as Therapy

Amantadine can reduce the severity and shorten the duration of influenza A illness among healthy adults. Although there are no similar data for high-risk persons, this does not preclude physicians from using amantadine for high-risk patients who develop illness compatible with influenza during a period of known or suspected influenza A activity in the community. Whether amantadine is effective when treatment begins beyond the first 48 hours of illness is not known.

- Students or other persons in schools and colleges if outbreaks would cause major disruptions of school activities.
- Persons traveling to the tropics at any time of the year or to countries south of the equator during April - September. (Persons with high-risk medical conditions and those ages 65 and older who are traveling as indicated above especially should be encouraged to receive vaccine.)

INFLUENZA VACCINE:

The viruses that cause flu frequently change, so people who have been infected or given a flu shot in previous years may become infected with a new strain. Because of this, and because any immunity produced by the flu shot will possibly decrease in the year after vaccination, persons in the high-risk groups listed above should be vaccinated every year. This year's flu shot contains the strains A/Texas/36/91-like, A/Beijing/353/89-like, and B/Panama/45/90-like to provide immunity against the types of flu which have been circulating in the past year, and/or thought to be most likely to occur in the United States next winter. All the viruses in the vaccine are killed so that they cannot infect anyone. Vaccine will begin to provide its protective effect after about one or two weeks, and immunity may decrease, on average, after several months. Flu shots will not protect all persons who get them against the flu. They also will not protect against other illnesses that resemble the flu.

DOSAGE:

Only a single flu shot is needed each season for persons 9 years of age and older, but children less than 9 years of age may need a second shot after about a month. The doctor or nurse giving the flu shot will discuss this with parents or guardians. Children less than 13 years old should be given only vaccine that has been chemically treated during manufacture (split virus) to reduce chances of any side effects. Split-virus vaccines can also be used by adults.

POSSIBLE SIDE EFFECTS FROM THE VACCINE:

Most people have no side effects from recent influenza vaccines. Flu shots are given by injection, usually into a muscle of the upper arm. This may cause soreness for a day or two at the injection site and occasionally may also cause a

fever or achiness for one or two days. Unlike 1976 swine flu vaccine, recent flu shots have not been clearly linked to the paralytic illness Guillain-Barré syndrome. As is the case with most drugs or vaccines, there is a possibility that allergic or more serious reactions, or even death, could occur with the flu shot.

SIMULTANEOUS USE OF OTHER VACCINES:

The target groups for influenza and pneumococcal vaccination overlap. Both vaccines can be given at the same time at different sites without increasing side effects. High-risk children may also receive influenza vaccine at the same time as measles, mumps, rubella, *Haemophilus influenzae* type b, and oral poliovirus vaccines, but at different sites. Influenza vaccine should not be given within 3 days of vaccination with pertussis vaccine.

WARNING! SOME PEOPLE SHOULD CHECK WITH A DOCTOR BEFORE TAKING INFLUENZA VACCINE:

- Persons with an allergy to eggs that causes a dangerous reaction if they eat eggs and those who have had a serious reaction to previous influenza vaccination should consult a physician before receiving the vaccine.
- Anyone who has ever been paralyzed with Guillain-Barré syndrome should seek advice from their doctor about special risks that might exist in their cases.
- Women who are or might be pregnant should consult with their doctor.
- Persons who are ill and have a fever should ask their doctor whether or not they should delay vaccination until the fever and other temporary symptoms have gone.

QUESTIONS:

If you have any questions about influenza or influenza vaccination, please ask now or call your doctor before requesting the vaccine.

REACTIONS:

If anyone receiving influenza vaccine gets sick and visits a doctor, hospital, or clinic in the 4 weeks after vaccination, please report this to:

PLEASE KEEP THIS PART OF THE INFORMATION SHEET FOR YOUR RECORDS

I have read or have had explained to me the information on this form about influenza and influenza vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and request that the vaccine be given to me or to the person named below for whom I am authorized to make this request.

INFORMATION ABOUT PERSON TO RECEIVE VACCINE (Please Print)					FOR CLINIC USE	
Name: Last	First	MI	Birthdate:	Age:	Clinic Identification:	
Address: Street			County:		Date Vaccinated:	
City			State		Manuf. and Lot No.:	
Zip			Site of Injection:			
Signature of person to receive vaccine or person authorized to make the request:						
X _____ Date: _____						

Influenza
7/1/92

FOR DATA PROCESSING USE ONLY (OPTIONAL)

VACCINE HISTORY:											
<input type="checkbox"/> Place check in box if history previously submitted											
DTP:					HAEMOPHILUS bPV:		HAEMOPHILUS bCV:				
m	d	yr	m	d	yr	m	d	yr	m	d	yr
POLIO:					MEASLES:		MUMPS:		RUBELLA:		
m	d	yr	m	d	yr	m	d	yr	m	d	yr

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Seeks association to practice affice gynecology. Board Certified. FACS. FACOG. Reply to Box 8.

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Pediatric group in Howard County needs BE/BC pediatrician to work 2/3's to full-time starting July 1993 or sooner. On call every seventh night. Competitive salary and benefits. Call Kenneth Klebanow, M.D. 410-997-1700.

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Sinai Hospital of Baltimore is now hiring part-time Pediatric Preceptors to work in the Emergency Room. For more information, please call Susan Moriarty, M.D. at 410-578-5737.

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BC/BE to join 4 orthopaedists in a large multispecialty group. Interest and expertise in spine surgery a plus. Extensive support system and modern facility located in Columbia, near the cultural advantages and medical schools of the Baltimore-Washington, DC area. Competitive salary, excellent benefits. Please direct CVs to: Patuxent Medical Group, Inc.; 2 Knoll North Drive; Columbia, MD 21045; Attn: Physician Recruiter. EOE M/F/H/V.

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Semi-retired or retired physicians for pleasant office practice part-time. Call 547-2686.

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SUBLET

Office to sublet in New Medical Office Building at St. Joseph's Hospital. Call 321-1514.

OFFICE FOR RENT

Mt. Vernon area. Near Medical Arts Bldg. Established orthopaedic office. Ground floor. X-ray on premises. Call 410-664-3344.

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Catonsville, Route 40, 1/2 mile west of Beltway exit 15B. 9 rooms, first floor. 1300 square feet. Will consider sub-dividing. Call Tony (O) 410-788-0600, (H) 410-461-4182.

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Send box replies or new ad copy to: Lori Robinson, MMJ, 1211 Cathedral St., Baltimore, MD 21201 or FAX 410-547-0915. Invoices are sent after the ad is published.

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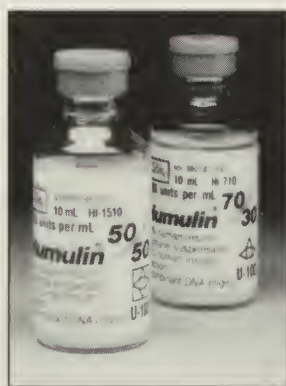
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The AMA and Our Alliance for Medical Liability Reform

Arguments for national medical liability reform have never been stronger; the current liability system not only drives up costs, but steers many physicians away from high risk specialties where malpractice suits are almost certain. For those who need care the most,—the young, poor and the elderly,—medical treatment is out of reach.

The American Medical Association has taken the lead and launched the *Alliance for Medical Liability Reform*, a grassroots alliance for change. Its goals are to restore fairness to our justice system, to control high health care costs and to turn up the volume on medical liability in the national health care reform debate.

Working with business, public health and other health care organizations, the AMA has already established the *National Liability Reform Coalition* to carry our message to Washington. At the grassroots level, the *Alliance* will continue to bring these issues to both Congress and the White House, to fight rising liability costs and end the need for defensive medicine.

You know that patient liability claims have more than doubled since the early eighties. Yet, most of these claims show no evidence of negligent medical care. But because liability premiums became the fastest growing practice expense, many cut back on staff, reduced services resulting in diminished access to care by their patients.

The following principles, developed by the *National Medical Liability Reform Coalition*, serve as reliable guidelines

for systematic, structured reform we can all live with. We need compensation for medical injury that provides...

1. **Available Health Care**, giving all Americans access to all necessary health care services.
2. **Quality Health Care**, that hinders substandard care and encourages quality improvements.
3. **Better Physician-Patient Relationships**, to enhance the professional relationship between physician and patient based on trust.
4. **Fair Compensation**, that is ample and just for patients injured by malpractice.
5. **Prompt Claims Resolution**.
6. **Innovation** in diagnosis and treatment, leading to continuous quality improvement.
7. **Predictable Outcomes** with respect to findings of liability and amount of rewards.
8. **Efficient and Economical Transaction Costs**.

The need for national medical liability reform has never been more pressing. The *Alliance* is gearing up to take this message to Washington. All that's missing is you! Take the first step and join our *Alliance* today. By uniting the concerned physicians of the AMA and their patients for reform, the *Alliance* will be a tremendous force for change in this decade. To join, call us toll free at 1-800-AMA-3211.

CHAIR

Department of Surgery

Liberty Medical Center presents an exceptional leadership opportunity to supervise the surgical program efforts at our 282-bed acute care community hospital.

In this key role, the selected individual will provide clinical direction, manage the staff and schedules, educate and train house officers, ensure continuous quality improvement and expand our surgical programs.

Candidates must have 5-10 years direct patient/clinical care experience, demonstrated management and leadership skills and board certification as a general or specialty surgeon.

For confidential consideration, please forward resume to: **Suzanne Q. Hoffman, Vice President, Human Resource Development, Liberty Medical Center, 2600 Liberty Heights Ave., Baltimore, MD 21215. EOE.**



Liberty Medical Center, Inc.

Christos Mastroyannis, M.D., F.A.C.O.G.

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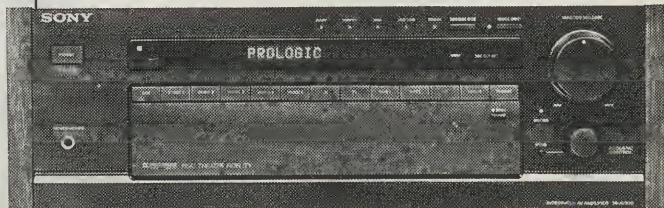
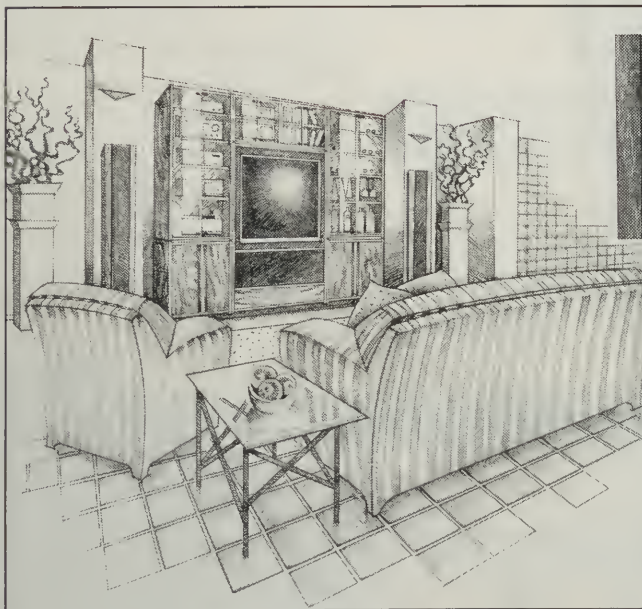
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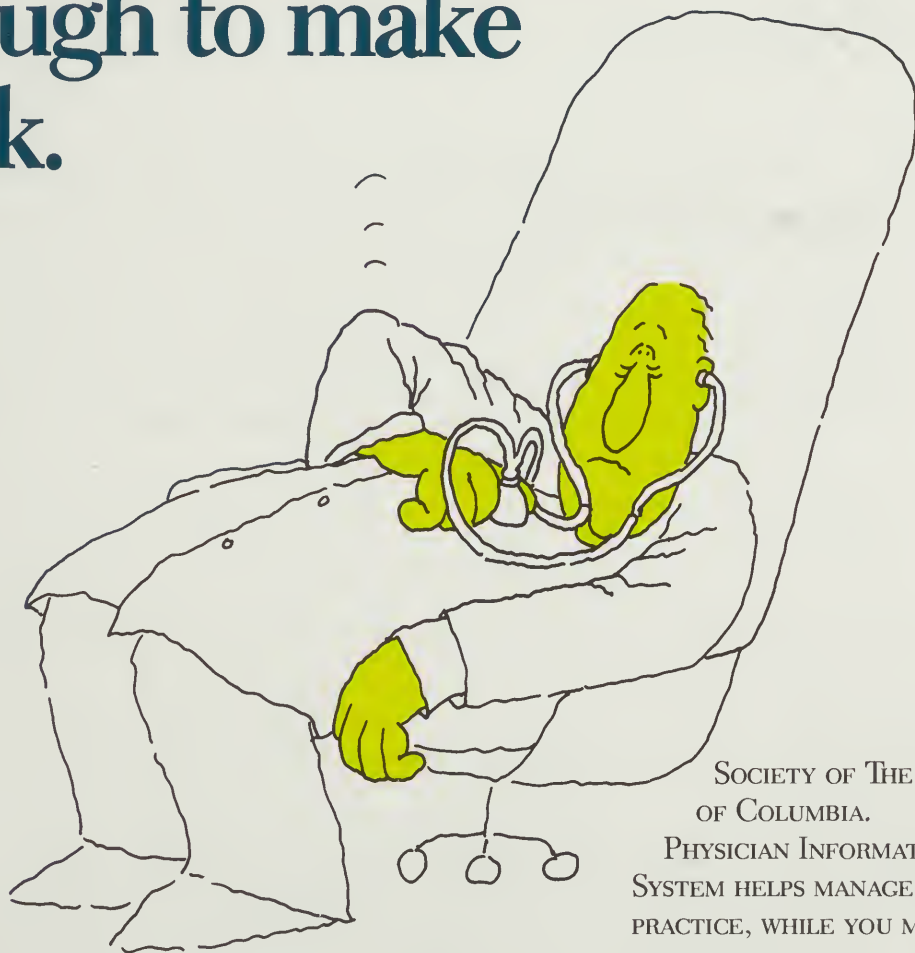


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Pursuant to §14-202 of the Health Occupations Article of the Annotated Code of Maryland, all licensed physicians in Maryland wishing to nominate candidates for initial vacancies on the Board of Physician Quality Assurance may submit nominations to the following address *by January 22, 1993*.

BPQA vacancies

The Medical and Chirurgical Faculty of Maryland
1211 Cathedral Street
Baltimore, Maryland 21201

Persons making nominations must certify that the nominee is willing to serve and is a practicing licensed physician as required by §14-202.

Please note that an election to select the names of physicians to be submitted to the Governor for possible nomination to the BPQA, *open to all licensed physicians in Maryland*, will be held on April 30, 1993, at the University of Maryland Center for Adult Education in College Park. Time and location of balloting will be announced in an upcoming issue.

MMJ

Maryland Medical Journal

DECEMBER 1992

VOLUME 41 NO 12

Anticipating Annapolis 1993: An interview with Jose Martinez, M.D., Med Chi Legislative Committee chairperson	1089
<i>Betsy Newman</i>	
"Health care played an enormous role in the recent election results. It will also be one of the most important issues in the Maryland General Assembly in 1993," says Jose Martinez, M.D., chairperson of Med Chi's Legislative Committee. During his term, Dr. Martinez and the more than 100 physicians serving on the Legislative Committee will recommend a Med Chi position on a number of issues affecting the medical profession.	
A doctor in the House	1093
<i>Vivian Smith</i>	
The only female physician ever elected to any US legislature, Dr. Bonsack's main areas of interest are access to care, and the quality and cost of care. She believes that government involvement has made it difficult to practice medicine as it should be practiced.	
Med Chi's response to the state budget crisis	1097
<i>Vivian Smith</i>	
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<i>Pegeen Townsend</i>	
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Erratum

In "Richard S. Ross, M.D.—Dean emeritus of the Johns Hopkins University School of medicine: An interview with MMJ's editor" (October 1992), Dr. Bert Vogelstein of the Hopkins Oncology Center was erroneously identified as Dr. Bert Goldstein. The managing editor regrets the error.

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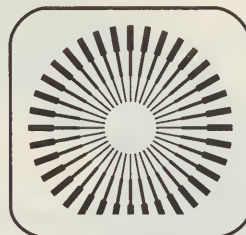


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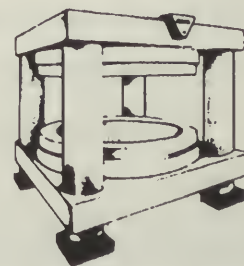
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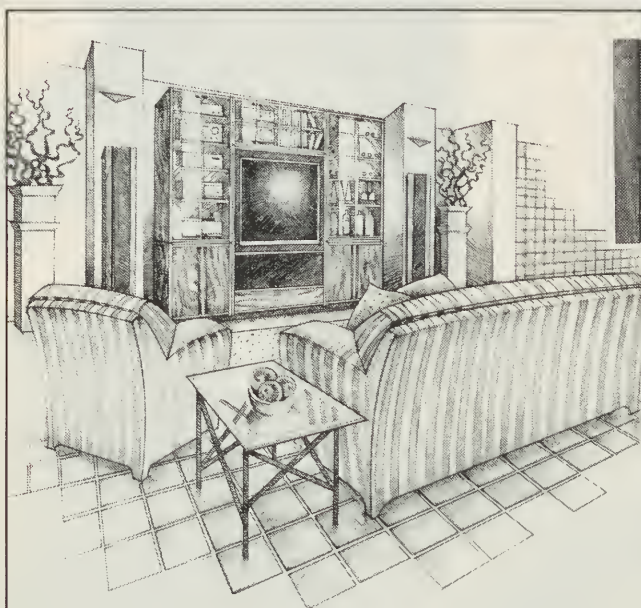
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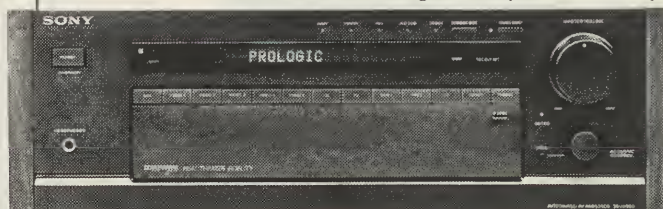
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Focus on Young Performers

Executive Director's Newsletter

December 1992

Med Chi Sponsors Press Conference in Response to State Budget Cuts

On November 23, 1992, Med Chi held a press conference to announce its cooperative effort with the Maryland Association of County Health Officers (MACHO) to provide voluntary medical services that will not be available as a result of state budget cuts. The following media covered the story:

Radio—WBAL-AM (Radio 1090) **Television**—WBAL-TV (Channel 11)
WBFF-TV (Channel 45)
WJZ-TV (Channel 13)

Newspapers—

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Baltimore Sun, Baltimore
Carroll Sun, Carroll County
Daily Banner, Cambridge
Daily Record, Baltimore
Daily Time, Salisbury
Evening Sun, Baltimore
Herald-Mail, Hagerstown

Howard Sun, Howard County
Montgomery County Journal,
Montgomery County
News Journal, Wilmington, DE
Post, Frederick
Prince George's Journal,
Prince George's County
Washington Times,
Washington, DC
USA Today, Washington, DC

For more on this topic, see the article on page 1097 of this MMJ.

Board of Physician Quality Assurance

In order to comply with §14-202 of the Health Occupations Article of the *Annotated Code of Maryland*, Med Chi is publishing an announcement, to all licensed Maryland physicians, in *Straight Forward* and the MMJ. *Straight Forward* is the official publication of the Physician Rehabilitation Committee and is mailed quarterly to all licensed physicians in Maryland.

All licensed physicians in Maryland wishing to nominate candidates for initial vacancies on the Board of Physician Quality Assurance may submit nominations to the following address until January 22, 1993

BPQA Vacancies
The Medical and Chirurgical Faculty of Maryland
1211 Cathedral Street
Baltimore, MD 21201-5585

Persons making a nomination must certify that the nominee is willing to serve and is a practicing licensed physician as required by §14-202 of the Health Occupations Article of the *Annotated Code of Maryland*.

An election, for the purpose of selecting names to be submitted to the governor for possible nomination to the BPQA, will be held at a date and time to be announced. All licensed Maryland physicians who bring proof of licensure will be eligible to vote in this election. Med Chi will print an advance ballot of nominees in the spring edition of *Straight Forward* and in the MMJ.

New Med Chi Policy on Gender-Neutral Language

On November 19, 1992, the Med Chi Council adopted a policy of incorporating gender-neutral language into all written and verbal communications. The new policy was adopted because Med Chi recognizes and encourages contributions from women physicians and is committed to eliminating gender-related barriers. The new policy is based on the recently adopted AMA Board of Trustees Report K (A-92) and was recommended by Med Chi's

Women in Medicine Committee. A copy of AMA Report K (A-92) may be obtained by calling Med Chi's Communications Department at 410-539-0872 or 1-800-492-1056. The AMA report recommendations are summarized below:

1. That the AMA adopt a policy of gender-neutral language, to be incorporated into its bylaws, policies, procedures, and publications, during the normal process of printing and updating/reprinting documents.
2. That the term "chairman" no longer be used to designate the head of a committee and that the term "chair" or "chairperson" be used instead.
3. That the AMA encourage state, county, and national medical specialty societies to review their bylaws and policies and eliminate gender-biased language where it exists.

*September 1992 Bylaws
Now Available*

Med Chi recently published a revised edition of the *Bylaws* based on changes made during the 1992 semiannual meeting. The new *Bylaws* have also been revised to include Med Chi's new policy on gender-neutral language. For a copy of Med Chi's *Bylaws*, contact Med Chi's Communications Department at 410-539-0872 or 1-800-492-1056.

*Performing Arts
Medicine Conference*

On Saturday, January 23, 1993, the Committee on Medicine and Performing Arts will sponsor "Overuse, Focal Dystonia, and Technique Impairment," a seminar from 2:00 p.m. to 5:00 p.m. at the Med Chi Faculty Building (1211 Cathedral Street in Baltimore). The seminar will address the relationships between painless and painful overuse and technique problems of instrumentalists. Information on etiology, occurrence, treatments, and outcomes of both overuse and focal dystonia will be included. There will also be discussion of a cooperative program between the National Institutes of Health and Catholic University's School of Music focusing on the relationship of these two disorders and technique impairment.

Speakers will be Mark Hallett, M.D., clinical director, National Institute of Neurological Disorders and Stroke; Thomas Mastroianni, Ph.D., chairperson of piano, Catholic University; and Hunter Fry, M.S., an Australian surgeon internationally known for his research on overuse syndromes. Following the presentations, there will be a panel discussion and a question and answer session. There is no charge for this seminar. Those wishing to attend, however, should make a reservation by contacting Susan Harman at 410-539-0872 or 1-800-492-1056.

*Performing Arts
Medicine Conference*

"Performing Arts Medicine II: Focus on Young Performers" is a conference on the special problems of performing artists scheduled to be held March 20-21, 1993 at the Med Chi Faculty Building, 1211 Cathedral Street, Baltimore. Sponsored by Med Chi's Committee on Medicine and Performing Arts, this conference is scheduled to include discussions on focal dystonia, eating disorders, Alexander and Feldenkrais techniques, drug side effects, conditioning and physical fitness, problems of marching musicians, and implications of the Americans with Disabilities Act. For more information about this conference, see the ad on page 1072 of this *MMJ*.

*Disposal of Mustard Gas
Program Scheduled for
1993 Annual Meeting*

Because the military currently plans to dispose of mustard gas at Maryland's Edgewood Arsenal, a program on the treatment for mustard gas exposure and on mustard gas disposal is scheduled to be featured during the Med Chi annual meeting from 12:30 p.m. to 5:00 p.m. on Thursday, April 29,

1992. The four-hour program will feature sections on treatment of poison gas intoxication and organophosphate insecticide intoxication, and precautions needed during decontamination. Invited guest speakers include Hank Siegelson, M.D. and Sanford Leffingwell, M.D. from the Centers for Disease Control in Atlanta. Watch the *MMJ* for more information about this upcoming program.

Tobacco Warning Labels

The Med Chi Committee on Alcoholism and Chemical Dependency and the Physician Rehabilitation Committee will publish and distribute tobacco warning labels to be placed on magazines, in physician waiting rooms, that contain tobacco advertising. The labels, which will be mailed to physicians in January 1993, contain the following message:

Warning: This magazine contains cigarette advertisements. Your physician does not support the use of any tobacco products or advertising of such products.

Watch the *MMJ* for more information about Med Chi's 1993 smoke-free Maryland campaign.

Thirteenth Annual Med Chi Photo Contest

Med Chi physicians and auxiliary members are encouraged to enter the 13th Annual Med Chi Photo Contest. First and second prizes will be awarded in both the color and black-and-white categories. All photographs submitted for the contest will be displayed during the 1993 Med Chi annual meeting at the University of Maryland University College Conference Center in College Park, Maryland. For complete contest rules, see the ad on page 1080 of this *MMJ*.

Award for Excellence in Organized Medicine

In the coming months, Maryland medical school deans will be asked to nominate senior medical students who have made outstanding contributions to organized medicine. Physicians who know or work with medical students are encouraged to tell these students about this award. Medical students are encouraged to contact the dean of their medical school to express their interest. Students must be members of Med Chi and must be involved in organized medicine. The award consists of a handsome engraved plaque and will be presented during Med Chi's annual meeting.

"Dear Doctor" Column

The Public Relations Committee is gathering articles to include in a "Dear Doctor" column to be published in various Maryland newspapers. The committee is currently recruiting additional physician volunteers to write articles for this column. Requirements for the articles in the column are as follows:

1. Articles should be written in a question-and-answer format —write as though a patient has just asked you a question (e.g., Question: What causes the common cold? Answer: There are a number of viruses that can cause a cold...);
2. Articles should be about a timely subject that is interesting to the general public;
3. Articles should be written in layperson terms — try to avoid medical jargon; and
4. Articles should be between 250 and 500 words in length.

All articles submitted for this project will be reviewed by the Public Relations Committee. Since the committee would like to have the "Dear Doctor" column appearing in area newspapers this spring, column submissions will

be accepted until February 15, 1993. For questions or more information about the "Dear Doctor" column, contact Betsy Newman or Vivian Smith in the Communications Department at 410-539-0872 or 1-800-492-1056.

President's Letter Errata

Due to printing deadlines, the resolution printed in the President's Letter on volunteer medical services in the November 1992 issue of the *Maryland Medical Journal* contained wording different than the resolution that was passed by Council on November 19, 1992. The resolution printed contained the wording of the proposed resolution. The resolution that was passed contains the following wording.

Therefore, Be it resolved that the Medical and Chirurgical Faculty of Maryland shall take a leadership position in responding to patient needs by encouraging each component medical society to work with their respective county/city health department to provide voluntarily, medical services which will not be available due to the reduction of funding for local health department programs.

Mark Your Calendars

House of Delegates, Council, and Executive Committee Meeting Dates for 1993

The dates for 1993 House of Delegates, Council, and Executive Committee meetings are listed below. House of Delegates meeting times are to be announced. All Council and Executive Committee meetings are held at 4:00 p.m. in the Med Chi Faculty Building, 1211 Cathedral Street in Baltimore, unless otherwise indicated.

House of Delegates

April 30, 1993—annual meeting

May 1, 1993—annual meeting

September 11, 1993—semiannual meeting

Executive Committee

February 18, 1993

April 15, 1993

June 17, 1993

August 19, 1993

October 21, 1993

December 16, 1993

Council

January 21, 1993

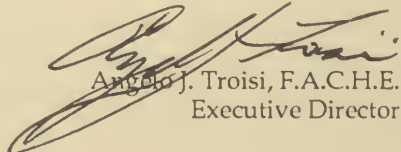
March 18, 1993

April 30, 1993, annual meeting

May 1, 1993, annual meeting

July 15, 1993

September 10, 1993, semiannual meeting



Angelo J. Troisi, F.A.C.H.E.
Executive Director

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Enter the Thirteenth Annual Med Chi Photo Contest



THIRTEEN MAY BE YOUR LUCKY NUMBER

Deadline for entries is Friday, March 19, 1993 ♦ Two categories: black & white or color
Open to all Med Chi and Auxiliary members ♦ First and second prizes awarded in each category

*All photographs will be displayed at the 1993 Annual Meeting at the University of
Maryland Adult Education Center, College Park.*

Photo Contest Rules:

Eligibility: All members of Med Chi and members of the Auxiliary may enter. Professional photographers may not enter. Members of the Photo Contest Committee and their families are not eligible.

1. Photographs may be submitted in two categories: black and white or color.
2. Limit: three entries per person.
3. Prints only, no smaller than 8 x 10" or larger than 11 x 14" will be accepted. If your favorite shot is a slide, you must have a print made within these size ranges to enter the contest.
4. Entries must be matted or dry mounted. No framed photographs will be accepted.
5. Entries must have name, address, and telephone number attached to the back of each photograph.
6. Entries may be mailed or brought to Med Chi, 1211 Cathedral Street, Baltimore, MD 21201 by the close of the business day on March 19.
7. Photographs entered in the contest will be on display at the 1993 Annual Meeting.
8. Prizes will be awarded to the first and second place winners.
9. Winners will be announced at the Annual Meeting of the Medical and Surgical Faculty, April 29–May 1, 1993.
10. Photographs will not be mailed back. Photographs may be claimed at the exhibit area at the close of the Annual Meeting at noon on May 1, or at Med Chi thereafter.
11. Med Chi does not guarantee against loss or damage of any kind to the photographs submitted to the contest.



The future of medicine— The doctor's role

Our country wants quality health care for all, and a fully capitalistic system cannot now provide it. Therefore, some degree of socialized medicine is already here and more is in the offing. We should not fight desirable and inevitable change, but we should try to direct it toward the good of all. We have a system that is still among the best in the world in terms of quality, which was achieved in good part by healthy competition and the freedom to innovate. We may have to accept big government as the source of funds and overall regulation, but we should fight regimentation and bureaucracy.

We should remember that most of our hospitals have been nonprofit all along, and it has been local pride and humanitarianism that have built our system, not capitalistic greed. We must preserve local control of our hospitals and personnel even though the government, as the primary payer, will have the ultimate control as to how much quality and quantity are possible. We cannot afford to have another centrally directed bureaucratic layer on top of our fairly efficient local bureaucracies, which already are responding adequately to government directives. The Veterans Administration hospitals, for example, needed local help to restore medical respectability, yet still are inefficient and hampered by a central bureaucracy.

The public can anticipate some loss of quality, convenience, and amenities if our evolving system is expected to serve more people for the same amount of money—but at least let our local peers apportion that loss. Most health professionals can expect lower fees

and salaries, but in the long run, the law of supply and demand will prevail. If the opportunities are better elsewhere, the system will lose necessary people, and hence will be forced to offer adequate recompense. The doctors may no longer be *prima donnas* and set their own fees, but they have already lost this privilege in part, and they still must be paid adequately to retain their services. This may be a come-uppance or a come-downance to some, but fortunately the innate satisfactions and fascinations of the field will continue to lure motivated people.

We can ask for some rewards in exchange for our cooperation, especially if we can show that those rewards would benefit the public and the government as well. Most of the “fat” has already been squeezed out of the system, and the only practical way government can lower expenses without lowering quality, is to lower administrative costs and to stop certain citizens from biting the hands that are trying to care for them. At present, in our half-socialized, half-free set-up, there are hopelessly confusing payment and responsibility problems with innumerable forms, and everybody is passing the buck. Only government has the power to consolidate fees, forms, and responsibilities, and it could do it for better or worse. If with our help, it is done for the better, it could cut the cost of medical care 10% or more. Only government has the power to eliminate the tort system in medicine, and in doing so, could achieve further savings of 20%–30%. It could and should at the same time assure the medically injured faster and more equitable remedy than at present, and maintain quality control—all is



possible with the same savings. Nobody would lose but the lawyers, and if the whole medical system is called upon to make sacrifices for the public good, they should be called upon also.

The public would benefit from both reforms, and the government, as payer or subsidizer, would benefit most of

all. Only through such savings can it reasonably offer "more for less" as most politicians seem to promise. It is up to the medical profession to see that the more comes from these and similar reforms rather than at the expense of quality of care.

mat of your medical journal to occasionally devote an entire issue to one subject. The effort to cover that subject in depth makes the issue a potential collector's item. Again, thank you for your interest in experimenting with this format. I encourage you to repeat the experiment from time to time.

CLIFFORD C. KUHN, M.D.
Louisville, KY

Compliments AND criticisms: We welcome hearing from you

"The Academy Movement" comprising the entire recent special edition of the *Maryland Medical Journal* is an impressive document. This excellent piece of psychohistory provided a happy interlude in my more usual professional reading.

Your are to be congratulated on this publication. The academy must be proud to now possess such an in-depth account of its carefully nurtured origins. The existence of such a fine history augers well for its continuing development and growing stature in the medical world.

HOMER O. ELSEROAD, Ed.D.
Ijamsville, MD

It was with considerable interest that I read the August edition of the *Maryland Medical Journal* featuring "The Academy Movement" by Dr. Henry P. Laughlin. That his proposal for a forum facilitating the exchange of ideas and relationships should have encountered resistance from the American Psychoanalytic Association (APsaA) has several parallels in classical mythology. One recalls with what disquiet the young Jason was received by his uncle Pelias, how the

infant Herakles was treated by Hera, or the reason Zeus bound Prometheus (later dramatized by Aeschylus and Shelley). In these cases, established powers recognized the challenge of youth to their heretofore unquestioned control. Is it so coincidental then, that both Drs. Laughlin and Thompson were a mere age 35 when they initiated the American Academy of Psychoanalysis and the Washington Psychiatric Society, respectively? And, that they ultimately succeeded! I thoroughly enjoyed reading this well-documented history.

DR. JOHN C. GEORGE
Frederick, MD

I am writing to congratulate you on the special edition of the *Maryland Medical Journal* dated August 1992, regarding the history of the development of the American Academy of Psychoanalysis. I found this fascinating reading not only from the historical perspective, which was painstakingly documented by your author Dr. Laughlin, but from the point of view of the personalities involved in this national effort.

In my opinion, it is a welcome change from the usual potpourri for-

I wish to commend you and *MMJ* on your August issue and its focus on the development of the academy movement. As a psychiatrist in Maryland, I found the history of the development of the psychoanalytic movement quite interesting and educational. Much can be learned from the political machinations of a generation ago. Understanding the role of psychoanalysis and its development in the United States has given me a much greater appreciation of the historical context from which psychiatry in the 1990s has come.

I also greatly appreciate your providing the space and emphasis for psychiatry and psychoanalysis, which have had a tremendous impact on society and the practice of medicine. Too often, psychiatric issues get lost in the excitement of new scientific development and current political activities. I have a greater appreciation for the scope of *MMJ* and look forward to seeing similar contributions in the future.

PHILIP H. LAVINE, M.D.
Cumberland, MD

Congratulations on your August issue. The inclusion of history is always significant and worthwhile. This edition of the *Maryland Medical Journal* is particularly note-



worthy as a detailed exposition of the founding of a major medical/psychiatric organization. The American Academy of Psychoanalysis has clearly become a significant force in the field.

Accordingly, this detailed account of its origins will be a longtime source for future research. This will ensure the longevity of this particular issue as an unprecedented special edition.

From Dr. Barton's excellent Preface (pp. 677-78) through Dr. Laughlin's quite personal Postscript (pp. 785-40), it is very readable and most interesting.

The editorial board and the author are to be complimented, and I trust there will be future endeavors of this calibre. Thank you.

FRANK H. LEWIS
Frederick, MD

Congratulations on the August issue of your journal. I must say it took me awhile to recognize the nature of the "special edition." The cover was nicely designed and except for the box in the right upper corner, one would have no clue to the nature of the contents.

When I started the foreword and acknowledgements, I felt like Ralph Kramden waiting for Norton to line up a pool shot: when is the author going to say something or get to the point?

Of course, I began to enjoy the special parody edition when I noticed the exaggerated style. The repetitious run-on sentences, the empty paragraphs, the minute details.... It reminded me of some clever pieces by Woody Allen in the *New Yorker*. The footnotes were particularly entertaining; the seniority numbers and the stilted conversations were great. The pompous tone was classic.

It has been awhile since there has been a good put-on like your special edition. Thirty years ago or so, college humor magazines would publish a parody issue of a national magazine—with similar surprises. The cover would seem normal but the contents would include normal text side by side with take-offs of ads, columns, and the like. Sometimes one couldn't be quite sure. They were great fun to read. I can just picture a group at your journal getting together to produce this issue.

I suppose if I were a psychoanalyst, I might think your parody a bit close for humor. In any case, keep up the good work. I look forward to other light pieces. We can all use a chance to laugh at ourselves.

P.S. Shouldn't the rear cover be a picture of the rear of Freud's head?

"A. KERR MUDGEON, M.D."

Congratulations on your excellent special edition of the journal, which I very much enjoyed. The fine foreword by our esteemed colleague Dr. Walter Barton is a great introduction. What follows is a highly accurate account in exquisite detail (including the many intriguing footnotes) of the Academy Movement culminating in the formation of the American Academy of Psychoanalysis. You have made a contribution to medical history by publishing this little psychiatric historical gem.

Having some personal awareness of the early struggles in psychoanalysis, this fine documentary took me back again to those challenging and at times professionally tumultuous years.

Dr. Laughlin's account is scholarly and well deserves preservation. His contributions to our academy are noteworthy. At the least, he certainly merits the long-belated recognition of honorary fellowship—with full credit for his pioneering, dedicated, and often arduous endeavors in its behalf. Your publication of Laughlin's document may even have some revitalizing influences on our academy of today.

Thank you for this issue.

P.S. Most present members will have little idea of the tremendous hardship involved.

ROBERT S. MUMFORD, M.D.
New York, NY

When did *MMJ* become the *Annals of Psychiatry*?

Why did you publish a sterile and esoteric institutional chronology as the August issue of *MMJ*? A more logical place for such an account would have been a psychoanalytic journal, don't you think?

What importance does this information have to society members? How many analysts—or even, how many psychiatrists—are truly interested in this history?

We are all aware how sorely sensitive physician self-aggrandizement issues are these days. In light of this, I was embarrassed by the August issue which read like an advertisement for one particular organization. Also, featuring a picture of an associate editor on the back cover, juxtaposed with that of Dr. Freud on the front, was tasteless and self-serving.

I look forward to next month's improved issue.

JONATHAN S. PLOTSKY, M.D.
Rockville, MD



I hope you will publish this letter as a letter to the editor. It concerns the August 1992 issue of your journal.

The term dynamics is often used in psychiatry. It means understanding the complex, interwoven interplay between external issues of reality and the conscious and unconscious internal mixture of ideas and emotions which affects perception and responses.

While classical psychoanalysis has focused more on unconscious internal constructs, the vast majority of psychiatrists have had a more holistic perspective. The American Academy of Psychoanalysis has been an important organized forum and voice for this broader understanding.

To have the history of the academy chronicled so thoroughly and well is not only important for archival purposes but a seminal contribution to the more widespread recognition of its significance to the practice of dynamic psychotherapy by all practitioners of the art.

Your journal is to be congratulated for publishing such an important issue.

HARVEY R. ST. CLAIR, M.D.
Louisville, KY

Recently I read the *Maryland Medical Journal*—Special Edition—The Academy Movement. I am particularly impressed by the journalistic talents of Dr. Henry P. Laughlin. His skills in assembling the incredible amount of historical, factual data on the origins of this outstanding professional organization are exemplarily chronicled.

Dr. Laughlin's status as an internationally recognized senior clinician and professor of psychiatry (plus being the author of several classic texts) is well known. The obvious painstaking research necessary to organize sequentially the data he has so outstandingly assembled, is not only readable, but extremely interesting.

I extend my kudos to Dr. Laughlin for his commendable effort, and to you and your staff, for the documentation and publication of this history. It will well serve as valuable reading for all of medicine and the American Academy of Psychoanalysis. The academy is extremely fortunate to have these data preserved for the future.

My congratulations, especially to Dr. Laughlin, whom you must be extremely proud and grateful of, as well as to yourself and your staff.

DR. R. S. WEST
Little River, CA

The August special edition of the *Maryland Medical Journal* detailing "The Academy Movement" is both informative and provocative. Congratulations are given to you and the editorial board on its publication.

An in-depth account, coupled with personal observations, provides a unique opportunity to glimpse the events leading to the formation of the academy. This publication makes a significant contribution to medical, particularly psychiatric, history. A richly rewarding endeavor from a knowledgeable and prolific author.

DR. THOMAS M. TARPLEY, CAPT.,
USPHS RET.
Woodsboro, MD

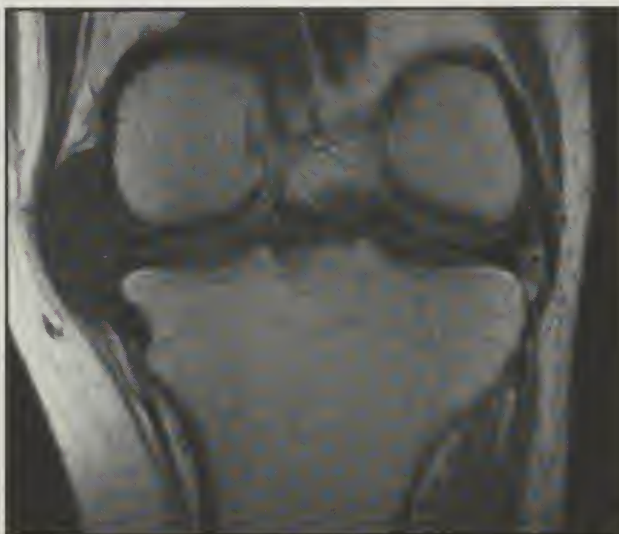
You and your editorial board members well merit a hearty commendation for publishing "The Academy Movement" in the *Maryland Medical Journal*. I believe this special edition is unprecedented for its great historical content.

Even though my medical specialty has been different, this account of the origins of a psychiatric movement and the founding of a major national organization is much appreciated. This data will long survive as an excellent reference, will enhance the longevity of our journal, and add to the renown of Med Chi.

Keep up the good work!

CHARLES H. WILLIAMS, M.D.
Catonsville, MD

Body Language



Coronal Scan of Left Knee.
Dx.: Meniscal Cyst



Sagittal T2-Weighted Scan of
Lumbar Spine. Dx.: Normal

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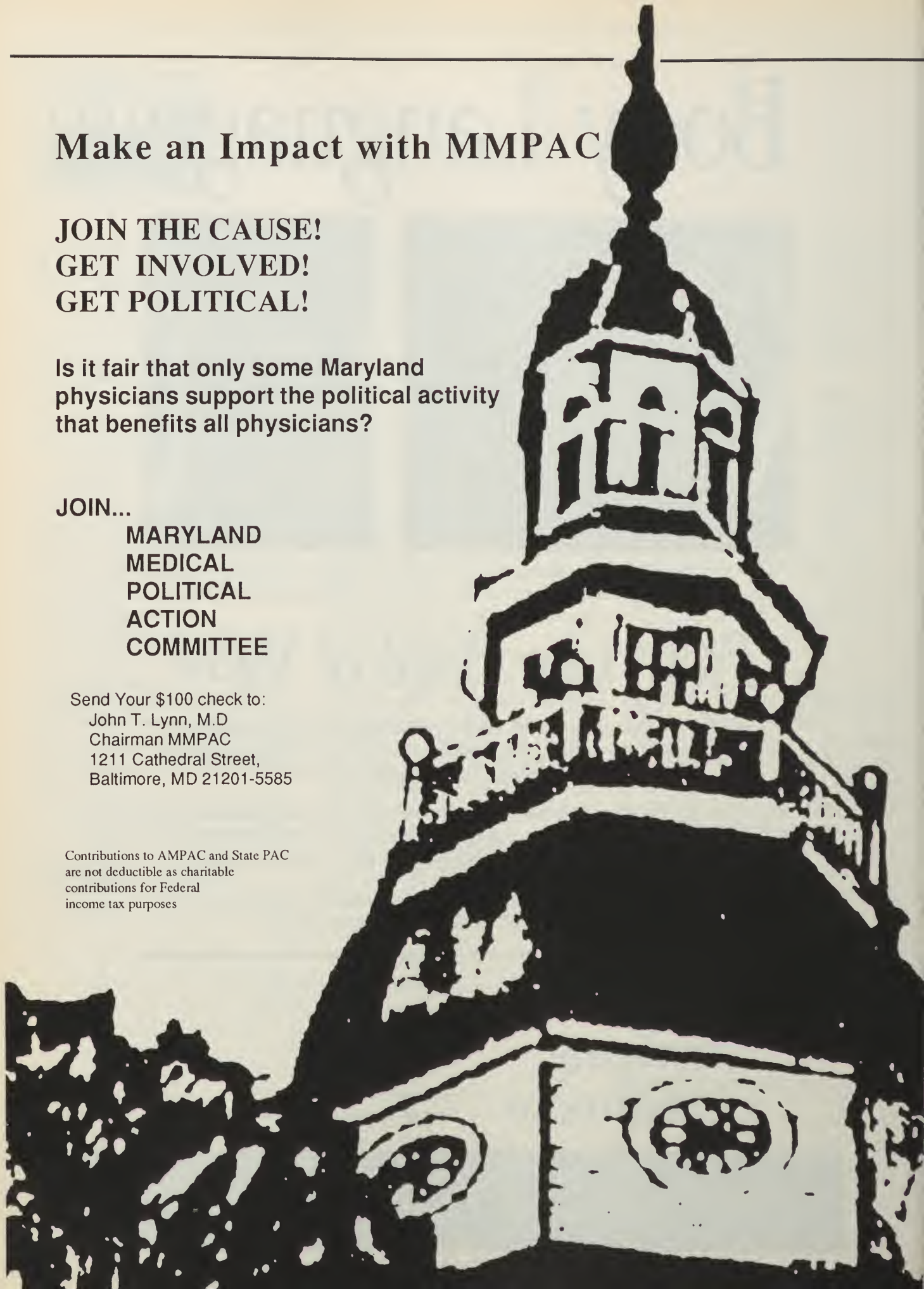
**Is it fair that only some Maryland
physicians support the political activity
that benefits all physicians?**

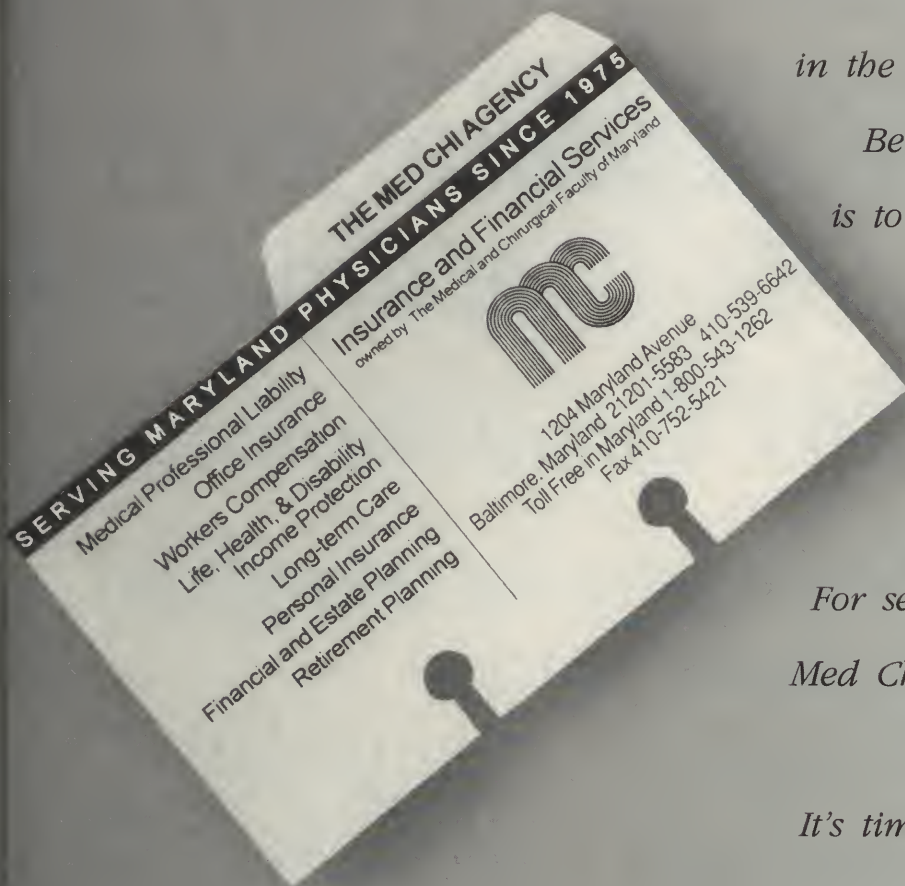
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requests papers on the theme

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for the

1993 Annual Meeting

at the

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Thursday - Saturday

April 29 - May 1, 1993

There is a growing awareness of the critical need for physician involvement in preventive care. This need is well recognized nationally, at the state level, and locally. Many disease states are preventable and certainly postponable. Physicians are in a unique position to influence a strong preventive ethic in Maryland. This year, Med Chi highlights the challenge and promise of preventive care as the theme for its annual meeting, "*Prevention 1993 - Maryland*."

Med Chi invites papers dealing with "*Prevention 1993 - Maryland*" for consideration by Med Chi's Committee on Scientific Activity.

For more information, call Med Chi's Office of Continuing Education at 410-539-0872 or 800-492-1056.

Anticipating Annapolis 1993:

An interview with Jose Martinez, M.D., Med Chi Legislative Committee chairperson

Betsy Newman

*Ms. Newman is director of communications at the Medical and
Chirurgical Faculty of Maryland.*

"Health care played an enormous role in the recent election results. It will also be one of the most important issues in the Maryland General Assembly in 1993," says Jose Martinez, M.D., chairperson of Med Chi's Legislative Committee. During his term, Dr. Martinez and the more than 100 physicians serving on the Legislative Committee will recommend a Med Chi position on a number of issues affecting the medical profession.

"There is no doubt that our health care system is in crisis," says Dr. Martinez. "However, it's often difficult to discern the symptoms of the problem from its actual causes. As a state, we face the danger of developing solutions only to the symptoms. It is my hope that Med Chi will work in conjunction with the legislature to develop solutions to the causes of the health care crisis."

Dr. Martinez maintains that physicians must present a unified front when dealing with governmental issues. "As a whole, legislative bodies are extremely reactive bodies," he says. "Many of the issues the legislature will address this year are a result of problems that surfaced last year or are matters that were not addressed during the previous legislative session. It's important that Maryland physicians understand all the issues that may surface during the upcoming session."

He encourages the members of Med Chi to contact their legislators. Med Chi will assist individual members in arranging such meetings. Dr. Martinez also requests that Med Chi members keep him informed of meetings with legislators that the members arrange on their own.

Public health

"Maintaining patient services and upholding the public health will also be a priority on the 1993 legislative agenda," says Dr. Martinez, who describes Med Chi's strategy on dealing with tobacco, HIV (human immunodeficiency virus) and other issues.

Tobacco. In an ongoing effort to prevent young people from using cigarettes and to discourage use of all tobacco products, Med Chi hopes to continue to work in alliance with the American Cancer Society—Maryland Division, the American Heart Association—Maryland Affiliate, and the American Lung Association of Maryland. In 1992, these groups helped support a measure that increased the tobacco tax by 20 cents per pack.

This coming year, the Med Chi Physician Rehabilitation Committee and the Committee on Alcoholism and Chemical Dependency plan to lead a major anti-smoking initiative. The committees plan to print labels that

can be affixed to magazines containing cigarette advertisements. Imprinted on each label will be the following message:

*This magazine contains cigarette advertisements.
Your physician does not condone the use of any tobacco
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The labels, which will be mailed to Maryland physicians and all state legislators, will kick-off Med Chi's 1993 anti-tobacco campaign.

AIDS/HIV. "This year, the Legislative Committee hopes to develop a number of positions that will allow physicians to treat HIV the same as any other sexually transmitted disease," says Dr. Martinez. Last session, eight bills dealing with mandatory testing of health care workers and/or patients were introduced and later defeated. While Med Chi policy opposes the mandatory HIV testing (screening) of the public, health care workers, or any other group not regulated by current law, Dr. Martinez hopes that Med Chi will lobby for a consent law similar to one in Virginia that allows for HIV testing of patients upon admission to a hospital. This concept appeared last session in bills such as S.B. 3, which would have required surgical patients to submit a blood sample for HIV testing prior to hospital admission. The Legislative Committee also supports the concept of reporting HIV infection. Last session, the Maryland General Assembly passed S.B. 277, which adds HIV and a low CD4+ count to the list of reportable diseases.

To help educate legislators about the spread of HIV, the Med Chi Committee on AIDS (acquired immunodeficiency syndrome) has proposed a special meeting between legislators and physicians to meet and discuss HIV and AIDS in Maryland. The committee hopes that a discussion of the modes of HIV transmission and the current needs of HIV/AIDS patients will help avoid superfluous and costly mandatory testing proposals, as well as help legislators establish realistic goals for public policy.

Other Med Chi public health initiatives during the upcoming session include the following.

- **Drug reimbursement**—Med Chi hopes to encourage legislation that would prohibit the adoption of regulations limiting the availability of certain drugs based on cost considerations. Specifically, the Department of Health and Mental Hygiene (DHMH) proposed to make available only those medications for which the manufacturer will rebate the cost to the state. While this may be considered for groups of medications where numerous manufacturers offer similar drugs, it is untenable for sole source drugs. Even in the first example, there are patients who manifest idiosyncratic reactions to certain drugs but who can tolerate others. This proposal can only have a negative impact on the quality of care.
- **Generic drugs**—The House of Delegates adopted as its policy in September 1992 an intention to see legislation introduced that would call for imprinting for identification of all generic, solid, oral drug products.

Health care financing

"We can expect a number of bills that will address health care costs," says Dr. Martinez. He explains that Med Chi will continue to support those bills benefiting Maryland medicine and oppose any legislation imposing an unnecessary or undue burden on physicians.

Self-referral. "One of the most debated issues last year was self-referral," says Dr. Martinez. During recent months, self-referral to laboratories and other facilities in which a physician has an ownership interest has sparked national interest. In December 1991, the American Medical Association (AMA) House of Delegates adopted a position that said, as a general rule, physicians should not engage in self-referral. In June 1992, however, the AMA voted to renege that opinion in favor of one allowing self-referrals as long as patients are fully informed of a physician's ownership interest and are notified of any alternative facilities.

The June 1992 AMA position is similar to Maryland law (Section 1-206), which requires physicians to post a notice in their offices regarding their ownership of health care services to which they refer patients. Despite this, however, Maryland legislators proposed H.B. 1374 last session. If passed, this bill would have prohibited certain health care practitioners from referring patients to services in which the practitioner or the practitioner's family had a financial interest or compensation agreement. "That law was defeated last year," says Dr. Martinez, "but I have no doubt that it will be reintroduced this year."

In response to continued physician concern about this issue, the Med Chi House of Delegates passed the following position on self-referral in September 1992:

1. Med Chi reaffirms its support of
 - a. the current 1991 Maryland State Disclosure Law, and
 - b. S.B. 654, the Board of Physicians Quality Assurance (BPQA) bill, which provides a mechanism to censure overutilization; and
2. Med Chi has established a special ad hoc committee to continue to study this very complicated and constantly evolving issue of self-referral to examine the effectiveness of current Maryland laws (as stated above), and that this ad hoc committee will continue to study this issue of self-referral legislation.

The ad hoc committee presented a preliminary report to the Med Chi Council in November. In the report, the ad hoc committee defines self-referral as "the situation in which a physician refers a patient to a health care provider (business), in which he/she has a financial interest, but does not perform any of the professional services." The ad hoc committee also presented the following position to the Council:

1. Self-referral, with disclosure of the financial relationship, is ethical.
2. Excessive overutilization for the purpose of the physician's financial benefit is unethical, whether or not it involves self-referral.

3. Self-referral is not illegal as long as it conforms to the terms of existing law.
4. Underutilization, in order to avoid the physician's financial loss, is also unethical, regardless of whether there is self-referral.

The ad hoc committee concludes, "Therefore, the problem is overutilization or underutilization resulting in a benefit to the physician." The ad hoc committee will present a second report to the Med Chi Council in January of 1993.

The most recent action regarding self-referral occurred December 8, 1992 at the AMA Interim Meeting, where the AMA House of Delegates reaffirmed its December 1991 position and rescinded its June 1992 decision by the following resolution:

Resolved, That the American Medical Association House of Delegates reaffirm the guidelines contained in Report C of the Council on Ethical and Judicial Affairs (I-91), Conflicts of Interest: Physician Ownership of Medical Facilities (Policy 140-961), as AMA policy; and rescind Resolution 5(A-92), Ethics of Self-Referral (Policy 140,959); and be it further

Resolved, That the Council on Ethical and Judicial Affairs be requested to continue to study and revise these guidelines as changes in the health system may require.

Fee capping. "We anticipate that there will be an effort to place caps on physician compensation," says Dr. Martinez, who states that during the 1992 session, legislation passed continuing the Health Services Cost Review Commission (HSCRC) until July 1, 2003. The HSCRC was established in 1971 to monitor all fiscal affairs of Maryland's hospitals and related institutions. As part of this fiscal monitoring, there have been movements during the last two years to regulate hospital-based physicians' fees. "We will continue to oppose any legislation that will cap the fees of any physician in any practice setting."

Hospital credentialing. "Another issue of great concern to Med Chi deals with the use of economics — that is, relating the net profit of a hospital to the amount of patient admission charges — as criteria for renewing or denying admission privileges to a physician." The legislative committee plans to encourage legislation to limit a hospital's ability to use economic criteria as the sole basis for credentialing.

Health care reform

"Last year, a number of bills were introduced that aimed to reform Maryland's health care system," says Dr. Martinez. Passing legislation established oversight committees such as the new Joint Committee on Health Care Delivery and Financing, which will study topics such as access to health care and health insurance, health care delivery, financing, and cost containment. Bills that failed included H.B. 374, which would have guaranteed access to health insurance coverage for small businesses and H.B. 376, which would have estab-

lished a special joint committee on access to health insurance coverage for all Marylanders.

Med Chi expects other health care reform proposals to be introduced in 1993 and is currently working in conjunction with the Maryland Alliance for Healthcare to establish its own health care reform proposal. The Maryland Alliance for Healthcare includes members from Med Chi, the Maryland Hospital Association, the Medical Data Analysis Company, Blue Cross and Blue Shield of Maryland, and Informed Physician Services. The alliance plans to address issues such as access to health care for all citizens, patient-focused delivery systems, cost containment, patient responsibility for health status, and practice parameters.

Professional regulation

"Med Chi plans to take a proactive stance on several regulatory issues affecting medical practice," says Dr. Martinez. He describes some of the initiatives enacted by the Legislative Committee.

International medical graduates. "One of the legislative actions taken last year allowed the BPQA to require a three-year training period or completion of an accredited postgraduate medical training period for international medical graduates (IMGs) before they are granted a license to practice medicine in Maryland," says Dr. Martinez. "Federal discrimination law now prohibits such actions. We hope the Maryland General Assembly will enact legislation to establish parity between IMGs and American medical graduates based on their degree of competence."

Other physician regulatory issues on Med Chi's legislative agenda include

- supporting initiatives by the Maryland Society of Eye Physicians and Surgeons to restrict the use of lasers to physicians and podiatrists;
- encouraging legislation that would allow physicians to perform acupuncture under the general authority to practice medicine; and
- advocating measures that would delay the BPQA's notification that a complaint had been filed until the certificate of merit was received by the Health Claims Arbitration Office.

Liability issues

"With respect to malpractice issues, we will oppose any attempt to repeal the existing cap on noneconomic damages," says Dr. Martinez. "We are also developing legislation to expedite the resolution of disputes on the treatment of patients as part of a worker's compensation procedure." He adds that Med Chi will support legislation from last session (H.B. 130) regarding insurance liability for volunteer physician services but encouraged expanded coverage to all physicians in charitable situations where services are uncompensated. Med Chi hopes to expand this proposal to include licensing fees and to tie this recommendation to the Good Samaritan Act.

Dr. Martinez explains that there are many other issues to

be discussed during the 1993 session and that there is an infrastructure of subcommittees that will address issues related to

- Boards and commissions,
- Public health,
- Health care costs and underwriting,
- Physician compensation, and
- Medical practices.

"The Med Chi Legislative Committee invites input from all Med Chi physicians," says Dr. Martinez. "During the legislative session, we will meet at least every other week and even weekly if we have to," he says. Dates of Legislative Committee meetings are available by calling Med Chi's main office (410-539-0872 or 800-492-1056).

"Med Chi was established in 1799 with the purpose of maintaining quality medical care for all citizens," says Dr. Martinez. "As chairperson of the Legislative Committee for 1993, I will do my best to ensure that we uphold the public health and physician interests." ■

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A doctor in the House

Vivian Smith

Ms. Smith is director of public relations at the Medical and Surgical Faculty of Maryland.

The only female physician ever elected to any US legislature, Dr. Bonsack's main areas of interest are access to care, and the quality and cost of care.

She believes that government involvement has made it difficult to practice medicine as it should be practiced.

“**T**hey preferred that I not go to medical school while I was pregnant,” explains Dr. RoseMary Hatem Bonsack, who married at the end of her sophomore year of medical school and immediately became pregnant. The University of Maryland School of Medicine, where she was a student from 1955 to 1957, held a meeting of the faculty and staff, who decided that she should not pursue the remainder of her junior year, stating that her first duty was to her husband and unborn child.

This obstacle did not keep Dr. Bonsack from earning her degree. Shortly after this conflict, her husband was transferred to Easton, Pennsylvania, and Dr. Bonsack attended her junior and senior year of medical school in Philadelphia, where she received her degree from the Medical College of Pennsylvania. Pursuing both her career and motherhood concurrently, Dr. Bonsack completed her medical internship at Easton Hospital, Pennsylvania with three children in diapers.

You may recognize Dr. Bonsack's name, but probably not from a glimpse you may have had of a medical office door. Dr. Bonsack is a member of the Maryland General Assembly's House of Delegates. Even more significant, Dr. Bonsack is the only woman physician ever elected to any legislature in the United States.

She explains this is most likely because there were few women in medical school in the late 1950s, and adds that, “the practice of medicine is really so time-consuming, that those who devote their time to taking care of patients, really do not take time to become involved with legislative or administrative issues to any extent.”

Although Dr. Bonsack admits that she misses not being able to devote as much time to her patients, her time is consumed with other responsibilities. Dr. Bonsack feels that there are too few family physicians in the United States; only 13% of physicians in the United States are family physicians. Because it is the family physician who oversees patients' needs and coordinates their care, Dr. Bonsack fears that “patients feel a loss when they do not have that generalist physician to help them make decisions as to their care.”

Dr. Bonsack credits both her medical and political career aspirations to a caring family and supportive parents, as well as having one brother in medicine, Dr. Fred Hatem, who also served in local government as a Harford County councilperson, and another brother, Tom Hatem, who, in government service for over thirty years, served as a delegate to the Maryland General Assembly and then as chairperson of the Public Service Commission and as the insurance commissioner. As Maryland's insurance commissioner, Tom Hatem worked with then Governor Marvin Mandel to bring about what is now known as the Medical Mutual Liability Insurance Society of Maryland.

Dr. Bonsack's interest in a medical-political career was sparked when she was elected by her peers to the Maryland State Board of Medicine in 1985 and realized that "so many of the new regulations governing physicians were coming out of the state legislature. The whole future of medicine was being affected by legislation."

Dr. Bonsack believes that physicians must realize that the medical profession is becoming fragmented. She is very concerned that "government has stepped in so many areas of the profession that it is difficult to practice medicine the way it should be practiced."

Dr. Bonsack's main areas of interest are access to care, quality of care, and cost of care. She has become involved with two commissions. Currently, she serves on the Commission on Cancer. Two major goals of the commission include discovering why Maryland's cancer rate is the highest in the United States and implementing preventive measures to fight cancer. In the near future, she will serve on a Commission on Health Care Delivery and Finance that is being formed by the state legislature. Through this program, Dr. Bonsack hopes to make health care more accessible to the uninsured and more affordable, while still maintaining the quality of health care.

Dr. Bonsack finds that her firsthand knowledge of the health care delivery system is an asset to the general assembly. She says, "even though many legislators are well meaning, many do not know a lot about the delivery of health care." Dr. Bonsack thinks that it would be advantageous to have "many more medical people, especially physicians [in the general assembly], to directly promote legislation that is appropriate for good quality medical care."

Governor William Donald Schaefer agrees. He says, "As a doctor, Delegate Bonsack brings a unique and welcome outlook to the legislature. Health issues are among the most important matters handled by the general assembly, and it's good to have someone knowledgeable in the medical field.



Dr. Bonsack practicing medicine.



Dr. Bonsack in her office with her brothers, Tom (l) and Fred (r).

Also, I appreciate her contributions to our cancer efforts and my administration's push for prevention of serious diseases, including cancer."

Although Dr. Bonsack has remained busy first with her medical practice, and now with her legislative career, she has always had a strong sense of family. Her husband Jim has been very supportive, both emotionally and financially. Her



Governor's 1989 proclamation establishing Family Practice Week. L to r: Earl Hill, M.D.; Joseph Zebley, M.D.; Governor Schaefer; RoseMary Bonsack, M.D.; and Joseph Connelly, M.D.



Dr. Bonsack's family participates in her installation by Speaker Clayton Mitchell. From l to r: Jeanette (daughter), Jay (son), Speaker Mitchell, Jim (husband), Karen (daughter), Dr. Bonsack, Kelly (daughter), and Tommy (son).

five children made a cooperative effort to help each other and their mom as they were growing up. Dr. Bonsack is very proud of her children, all of whom have pursued or are pursuing a career in the health care field.

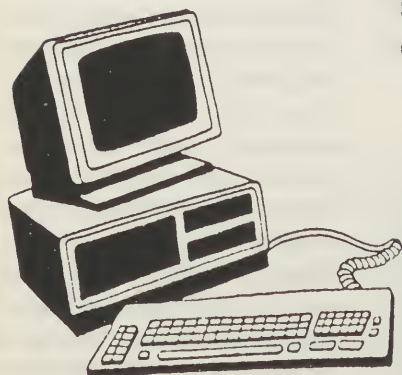
Although it isn't on her curriculum vitae, with her five children all of whom were into athletics, Dr. Bonsack served as team doctor for a lot of teams. She misses that, admitting, "I really enjoyed my children. I enjoy young people, and I do a lot of work with young people." Once a year for over 20 years, she has given "all the sex talks" at St. Joan of Arc School, referring to them as lectures on human reproduction.

Aside from her enjoyment of children she also has two other passions—dancing and cooking. Although she doesn't have much of an opportunity to dance, she steals the chance when she attends social functions as part of her job. But cooking is something she does everyday when she's not in session. Dr. Bonsack is of Lebanese ancestry and does a lot of Lebanese cooking. She credits herself with being a creative cook and seldom makes two dishes the same way. This frustrates her children when they ask for a recipe because she says, "I don't know what the recipe is. That's my fun."

This philosophy carries over to her life. She lives by a philosophy which says, "I'm not afraid of tomorrow, for I have seen yesterday, and I love today." She continues to persevere from day to day and doesn't see an end to a career. She admits, "I just try to do what I can each day, and try to accomplish as much as I can and hope that I can get some good things done as I go along." ■

What to look for in Office Computers

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Med Chi responds to state budget crisis

Vivian Smith

Ms. Smith is director of public relations, Med Chi.

On November 19, 1992, Med Chi's Council passed the following resolution that details the ramifications of recent state budget cuts, emphasizes Maryland physicians' commitment to health care in the state, and encourages each county/city medical society to work in harmony with their respective county/city health department to voluntarily provide medical services that will be reduced or eliminated due to reduced funding for health department programs.

The programs that are expected to be affected include childhood immunizations, influenza vaccinations, HIV/AIDS (human immunodeficiency virus/acquired immunodeficiency syndrome) counseling, sexually transmitted disease evaluations, ENT (ear, nose, throat) examinations, and a host of other preventive measures. In total, the proposed budget cuts are expected to trim \$50 million from medical care and eliminate services for 30,000 of the state's poorest residents.

Med Chi representatives met with the Maryland Association of County Health Officers (MACHO) and representatives from the Department of Health and Mental Hygiene (DHMH) over the past several months and concluded that not providing preventive measures to our citizens will most certainly result in higher costs of providing acute care to this population in the future.

Med Chi announced its effort at a press conference held on November 23, 1992 at the Faculty building. The conference was attended by reporters from the *Sun*, the Associated Press, WBAL Channel 11 News,



Med Chi leaders met with the Maryland Association of County Health Officers (MACHO) on October 15, 1992 to discuss state budget cuts to health department programs. L to R: Ron Bialek, M.P.P., MACHO staff; Virginia Seyler, M.H.S., MACHO staff; Marty Wasserman, M.D., M.P.H., MACHO chairperson; Joseph Fastow, M.D., Med Chi Council chairperson; and John Grant, M.D., M.P.H., MACHO vice-chairperson.

and Fox 45 News At Ten. The story was also covered by WBAL Radio, WJZ Channel 13 News, and the *Washington Times*.

Governor William Donald Schaefer praised Med Chi for responding to the needs of Maryland residents who have been affected by recent state budget cuts saying, "I am pleased the Medical and Chirurgical Faculty has stepped forward in an effort to fill the gap. It proves to me that the spirit of volunteerism remains very strong in Maryland."

It is Med Chi's purpose to promote satisfactory distribution of medical care to the citizens of Maryland, and a look back will show numerous resolutions responding to patients' needs regardless of ability to pay. And, Maryland itself has always been committed to health care, as evidenced by its creation of the first department of health in the United States some 200 years ago. ■



Med Chi President Jose M. Yosiuco, M.D. expresses Med Chi's eagerness to help county health departments during the current budget crisis. L to R: Marty Wasserman, M.D.; John Grant, M.D.; and Jose M. Yosiuco, M.D.

L to R: Jose M. Yosiuco, M.D., president, Med Chi; Margaret Sherrard, M.D., M.P.H., Baltimore County health officer; Virginia Bailey, M.D., M.P.H., Cecil County health officer; Lee Jones, M.D., M.P.H., Dorchester County health officer; Jim Bowes, M.D., M.P.H., Frederick County health officer; Joyce Boyd, M.D., M.P.H., Howard County health officer; Mary Mussman, M.D., M.P.H., Somerset County acting health officer; and Angelo J. Troisi, F.A.C.H.E., executive director, Med Chi.

Resolution of the Medical and Chirurgical Faculty of Maryland

Whereas the state of Maryland proposes a \$150 million cut in state funds to the 23 counties and Baltimore City;

Whereas these budget cuts will trim \$50 million in medical care and eliminate services for 30,000 of the state's poorest residents;

Whereas these budget cuts will eliminate programs that help pay staff in local health departments and reduce grants to community mental health clinics;

Whereas needy citizens may not receive the necessary medical care from any other source;

Whereas the profession of medicine has always provided care to those in need;

Whereas the physicians of Maryland have always held high the importance of public health as evidenced by the creation of the first department of health in the United States, some 200 years ago;

Whereas these financial reductions will result in a decrease or total deletion of such services as childhood immunizations, influenza vaccinations, HIV/AIDS counseling, sexually transmitted disease evaluations, ENT examinations, orthopaedic examinations, and a host of other preventive measures;

Whereas not providing these "preventive" measures to needy citizens will result in a higher cost of providing "acute" care to this population in the future; therefore be it

Resolved That the Medical and Chirurgical Faculty of Maryland shall take a leadership position in responding to patient needs by encouraging each component medical society to work with their respective county/city health department to provide, voluntarily, medical services, which will not be available due to the reduction of funding for local health department programs.

Resolution 992

Approved this day November 19, 1992

Utilization review: Legislative history

Pegeen Townsend

Ms. Townsend is staff counsel for the Environmental Matters Committee, Maryland House of Delegates.

Maryland's ability to maintain its Medicare waiver hinges on its ability to contain health care costs. Utilization review was initiated in 1985 as one means to reduce unnecessary spending.

In Maryland, there is a unique relationship between health care cost containment and access to care for all citizens due to our Medicare waiver. The waiver requires all payers to share equally in the cost of bad debt and charity care by paying the rate for hospital services set by the Health Services Cost Review Commission (HSCRC). This means that in Maryland, there is no need for public acute general hospitals, and the 500,000 uninsured Marylanders have unparalleled access to needed hospital services. The waiver system financed more than \$246 million in uncompensated care last year (1991). It also generated more than \$100 million in federal payments to help pay for the care of Maryland's poor and more than \$600 million in Medicaid savings. Since its inception, the waiver has saved Marylanders five billion dollars.

Our ability to keep the waiver hinges on our ability to contain health care costs. The average rate of increase in costs to Medicare under the Maryland system must be equal to or less than the rate of increase Medicare pays in other states.

In order to meet this test, Maryland has taken serious steps to contain health care costs. In 1985, several bills were enacted to promote a downsizing of the hospital system by facilitating mergers and closures of hospitals with excess capacity. In addition, to eliminate unnecessary or duplicative use of inpatient services, each hospital was required to establish a utilization review program as a condition of licensure. Hospital utilization review programs must include

- Preadmission review of elective admissions;
- Postadmission review of emergency admissions;
- Concurrent or retrospective review of all admissions as appropriate;
- Preauthorization of certain selected procedures if proposed to be performed on an inpatient basis;
- Second surgical opinions for certain surgical procedures to be performed on a nonemergency basis;
- Continued-stay review based on recognized objective criteria;
- Discharge planning review; and
- Readmission review.

A hospital is exempt from the required utilization review for a patient if the patient is insured by a third-party payer that has a utilization review program for its subscribers or the patient is a member of a health maintenance organization (HMO).

Due to the increasing reliance on utilization review by third-party payers, the number of private review agents greatly expanded, creating severe administrative problems for hospitals and other providers. The hospitals and providers were faced with numerous utilization review standards and systems which made determinations of appropriate services that were medically necessary, difficult from a reimbursement standpoint. In 1988, Maryland enacted legislation to require private review agents to register and obtain a certificate from the secretary of the Department of Health and Mental Hygiene (DHMH) prior to conducting utilization review activities in the state. This law was the first of its kind in the country and has subsequently become a model for those states now regulating private review agents.

During deliberations on this bill, the controversy over whether to require private review agents to disclose the criteria used to make their determinations was hotly debated, as was the issue of whether to exempt HMOs from the purview of the bill. Insurers argued that the criteria and standards they used were proprietary in nature and cost a great deal of money to develop, and that by releasing the information, providers would be able to "game the system." The HMOs argued that they were different from others conducting utilization review because their patients were in a total managed care system.

At that time, the legislature decided that in order to become certified, a private review agent, including the utilization review component of an HMO, must submit a utilization review plan that includes

- A description of the review standards and procedures to be used in evaluating proposed or delivered hospital care;
- Those circumstances, if any, under which utilization review may be delegated to a hospital utilization review program; and
- The provisions by which patients, physicians, or hospitals may seek reconsideration or appeal of an adverse decision of a private review agent.

The private review agent is also required to submit information on the type and qualifications of the personnel used to conduct the review; the procedures and policies used to ensure that the private review agent is reasonably accessible during normal business hours; and information on the procedures used to ensure that the state and federal laws to protect patient confidentiality are followed.

The 1990 session of the legislature again brought issues concerning utilization review before the Maryland General Assembly. Concerns were expressed about the standards and criteria used by private review agents when performing utilization review of services related to the treatment of alcoholism, drug abuse, and mental illness. Testimony indicated that

utilization review in these areas has been used to circumvent state law mandating insurance companies to provide specified coverage for the treatment of these illnesses (e.g., up to seven days of inpatient detoxification care, up to 30 days of inpatient rehabilitative care for drug and alcohol abuse, 30 outpatient visits for drug and alcohol abuse, and 30 days of inpatient care for the treatment of mental illness). Although this insurance coverage is mandated, it has been the experience of some patients and providers that private review agents would only approve treatment in the less costly outpatient setting. In an effort to address these concerns, legislation was enacted mandating—for reviews of services for the treatment of alcoholism, drug abuse, and mental illness—that

- Decisions to deny or reduce coverage be made only by a qualified physician;
- Final determinations of appeals by patients or providers be decided only by a physician—selected by the private review agent—who is board certified or actively practicing in the kind of care under review and who is not compensated in a manner that gives a financial incentive to deny or reduce care;
- Any final decision to reduce or deny care be in writing and cite the specific utilization review standards or criteria, including interpretive guidelines, upon which the decision was based; and
- Once preauthorized or otherwise approved, the private review agent may not change the standards or criteria to reduce or deny coverage during the course of the treatment.

In 1991, legislation relating to patient referrals by private review agents was enacted to prohibit a private review agent or any individual affiliated with, under contract with, or acting on behalf of a private review agent, from

- Referring a patient who has undergone utilization review by the private review agent to a health care facility where the private review agent owns an interest (5% or \$5,000) or to the private review agent's own health care practice;
- Paying or agreeing to pay any sum to, or accepting any sum from, any person for bringing or referring a patient to the private review agent; or
- Providing for different insurance coverage or benefits based on receiving the service from a health care facility or health care provider in which the private review agent owns an interest (5% or \$5,000).

The 1991 legislation also provided the secretary of DHMH with the authority to impose administrative penalties of up to \$1,000 for a violation of any provision of the statute regulating private review agents.

Legislation enacted during the 1992 session requires private review agents, as a condition of certification, to submit to the secretary of DHMH the specific criteria and standards the agent will use in conducting utilization review of proposed or delivered health care services. The private review agent

must certify that the criteria and standards to be used in conducting utilization review are (1) objective; (2) clinically valid; (3) compatible with established principles of health care; and (4) flexible enough to allow deviations from norms when justified on a case by case basis.

On the written request of any person or health care facility, the private review agent must provide one copy of the specific criteria and standards to the person or health care facility making the request. The legislation also requires that all adverse decisions related to proposed or delivered health care services be made by a physician or a panel of other appropriate health care providers with at least one physician on the panel. If a patient or health care provider appeals an adverse decision by a private review agent, the final determination of the appeal must be stated in writing, provide an explanation of the reason for the adverse decision, and reference the specific criteria and standards, including interpretive guidelines, upon which the adverse decision is based.

Any determination as to whether to authorize or certify a

nonemergency course of treatment for a patient must be made within two working days of the receipt of all the information necessary to make the determination. Determinations on whether to certify an extended stay in a health care facility or additional health care services must be made within one working day, and if a determination is made not to authorize an extended stay or additional health care services, the attending health care provider must have the opportunity to seek a reconsideration of that determination within 24 hours of the health care provider seeking the reconsideration. In addition, for emergency inpatient admissions, a private review agent may not render an adverse decision or deny coverage for medically necessary covered services solely because the hospital did not notify the private review agent of the admission within 24 hours or other prescribed period of time after that admission if the patient's medical condition prevented the hospital from determining the patient's insurance status and the private review agent's emergency admission notification requirements. ■

Private review agent law

A. General provisions

Subtitle 13 of Title 19 of the Health-General Article requires any private review agent conducting utilization review in Maryland to obtain a certificate from the secretary of the Department of Health and Mental Hygiene. A "private review agent" is defined as a non-hospital affiliated person or entity performing utilization review that is either affiliated with, under contract with, or acting on behalf of

- (1) A Maryland business entity; or
- (2) A third party that provides or administers hospital benefits to citizens of this state, including:
 - (i) A health maintenance organization issued a certificate of authority in accordance with Subtitle 7 of this title; or
 - (ii) A health insurer, nonprofit health service plan, health insurance service organization, or preferred provider organization authorized to offer health insurance policies or contracts in this state in accordance with Article 48A of the Code.

To obtain a certificate, the private review agent must submit

- (1) A utilization review plan that includes
 - (i) The specific criteria and standards to be used in conducting utilization review of proposed or delivered services;
 - (ii) Those circumstances, if any, under which utilization review may be delegated to a hospital utilization review program; and
 - (iii) The provisions by which patients, physicians, or hospitals may seek reconsideration or appeal of adverse decisions by the private review agent;

- (2) The type and qualifications of the personnel either employed or under contract to perform the utilization review;
- (3) The procedures and policies to ensure that a representative of the private review agent is reasonably accessible to patients and providers five days a week during normal business hours in this state;
- (4) The policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual medical records are followed;
- (5) A copy of the materials designed to inform applicable patients and providers of the requirements of the utilization review plan;
- (6) A list of the third-party payers for which the private review agent is performing utilization review in this state;
- (7) The policies and procedures to ensure that the private review agent has a formal program for the orientation and training of the personnel either employed or under contract to perform the utilization review;
- (8) A list of the health care providers involved in establishing the specific criteria and standards to be used in conducting utilization review; and
- (9) Certification by the private review agent that the criteria and standards to be used in conducting utilization review are
 - (i) Objective;
 - (ii) Clinically valid;
 - (iii) Compatible with established principles of health care; and
 - (iv) Flexible enough to allow deviations from norms when justified on a case by case basis.

The statute requires the secretary to deny a certificate to an applicant that does not

- (1) Have available the services of sufficient numbers of registered nurses, medical records technicians, or similarly qualified persons supported and supervised by appropriate physicians to carry out its utilization review activities;
- (2) Meet any applicable regulations the secretary adopts relating to the qualifications of private review agents or the performance of utilization review; and
- (3) Provide assurances satisfactory to the secretary that
 - (i) The procedures and policies of the private review agent will protect the confidentiality of medical records in accordance with applicable state and federal laws; and
 - (ii) The private review agent will be accessible to patients and providers five working days a week during normal business hours in this state.

B. Disclosure of UR criteria and standards

As part of the application for a certificate, a private review agent must submit the specific criteria and standards to be used in conducting utilization review of proposed or delivered services. At least 10 days before a private review agent requires any revisions or modifications to the specific criteria and standards, the private review agent must also submit those revisions or modifications to the secretary.

Additionally, on the written request of any person or health care facility, the private review agent shall provide one copy of the specific criteria and standards and any modifications to the criteria and standards to the

person or health care facility making the request. Private review agents are authorized to charge a reasonable fee for copies of the criteria and standards and any subsequent revisions or modifications.

In the event a patient or health care provider seeks a reconsideration or appeals an adverse decision by a private review agent, the final determination of the appeal of the adverse decision must

- (1) Be stated in writing and provide an explanation of the reason for the adverse decision; and
- (2) Reference the specific criteria and standards, including interpretive guidelines, upon which the adverse decision is based.

C. Appeals of adverse decisions

An "adverse decision" is defined to mean a utilization review determination made by a private review agent that a proposed or delivered health care service

- (1) Is or was not necessary, appropriate, or efficient; and
- (2) May result in noncoverage of the health care service.

There is no adverse decision if the private review agent and the health care provider on behalf of the patient reach an agreement on the proposed or delivered health care service.

All adverse decisions must be made by a physician or a panel of other appropriate health care providers with at least one physician on the panel. In the event a patient or health care provider seeks a reconsideration or appeals an adverse decision by a private review agent, the final determination of the appeal of the adverse decision must be made based on the professional judgment of a physician or a panel of other appropriate health care providers with at least one physician on the panel. Additionally, the final determination of the appeal of the adverse decision must

- (1) Be stated in writing and provide an explanation of the reason for the adverse decision; and
- (2) Reference the specific criteria and standards, including interpretive guidelines, upon which the adverse decision is based.

Lastly, a private review agent may not charge a fee to a patient or health care provider for an appeal of an adverse decision.

D. Time frames for decisions

Private review agents are required to make all initial determinations on whether to authorize or certify a nonemergency course of treatment for a patient within two working days of receipt of the information necessary to make the determination and to promptly notify the attending health care provider and patient of the determination.

All determinations on whether to authorize or certify an extended stay in a health care facility or additional health care services must be made within one working day of receipt of the information necessary to make the determination and the private review agent must also promptly notify the attending health care provider of the determination.

If an initial determination is made not to authorize or certify a course of treatment, an extended stay in a health care facility, or additional health care services, and the attending health care provider believes the determination warrants an immediate reconsideration, the private review agent must provide the attending health care provider an opportunity to seek a reconsideration of that determination by telephone on an expedited basis not to exceed 24 hours of the health care provider seeking the reconsideration.

E. Review of services for treatment of alcoholism, drug abuse, or mental illness

In addition to the requirements applicable to all private review agents, those performing utilization review of services related to the treatment of alcoholism, drug abuse, or mental illness must meet several other requirements. All adverse decisions and the final determination of an appeal of an adverse decision must be made by a physician, or a panel of other appropriate health care providers with at least one physician, selected by the private review agent, who is

- (1) Board certified or eligible in the same specialty as the treatment under review; or
- (2) Actively practicing, or has a demonstrated expertise, in the alcohol, drug abuse, or mental health service or treatment under review.

The physician also may not be compensated by the private review agent in a manner that provides a financial incentive directly or indirectly to deny or reduce coverage.

F. Patient referrals by private review agents

A private review agent or any individual who is either affiliated with, under contract with, or acting on behalf of a private review agent may not

- (1) Refer a patient who has undergone utilization review by the private review agent to
 - (i) A health care facility in which the private review agent owns a significant beneficial interest (5% or \$5,000); or
 - (ii) The private review agent's own health care practice;
- (2) Pay or agree to pay any sum to, or agree to accept any sum from, any person for bringing or referring a patient to the private review agent; or
- (3) Provide for different insurance coverage or benefits based on receiving the service from a health care facility or

health care provider in which the private review agent owns a significant beneficial interest (5% or \$5,000).

A private review agent may refer a patient to another health care provider if

- (1) (i) The patient or provider requests the private review agent to provide the patient with the name of the health care provider appropriate to meet the health care needs of the patient; or
(ii) The patient has no attending physician; and
- (2) The private review agent provides the patient with the names of at least two health care providers appropriate to meet the health care needs of the patient.

The prohibitions on patient referrals by private review agents however, do not apply to

- (1) A private review agent referring an individual to a health care provider or facility that participates in a health maintenance organization; or
- (2) A preferred provider organization network of participating health care providers or facilities to which the individual would otherwise be referred as part of the individual's membership or insurance contract.

G. Confidentiality

As part of the application for a certificate, a private review agent must submit the policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual medical records are followed. The statute specifically requires the secretary to deny a certificate to any applicant that does not provide assurances satisfactory to the secretary that the procedures and policies of the private review agent will protect the confidentiality of medical records in accordance with applicable state and federal laws. The statute also specifically prohibits a private review agent from disclosing or publishing individual medical records or any other confidential medical information obtained in the performance of utilization review activities.

H. Penalties

The statute provides for a criminal penalty not to exceed \$1,000 for violating any provision of the statute or any regulation adopted under the statute. Each day a violation is continued after the first conviction is a separate offense.

In addition to the criminal penalties, the secretary may impose an administrative penalty of up to \$1,000 for a violation of any provision of the subtitle regulating private review agents.

The secretary may also revoke the certificate of a private review agent, after an opportunity for a hearing, for a violation of the statute or any regulation adopted under the statute. ■

The 1993 Medical and Chirurgical Faculty of Maryland state legislative directory

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Legislative information & library

From Baltimore area841-3810

From Washington area.....858-3810

Elsewhere in MD ..1-800-492-7122
ext. 3810

The legislative process*

From hopper to enactment

The drafting of legislation requires the skill of experienced and trained personnel. This service is rendered by the Department of Legislative Reference. A bill or joint resolution may be introduced in advance of regular sessions and is styled a "prefiled bill." A bill is filed (is dropped into the hopper) with the secretary of the Senate or the clerk of the House, is given a number, and is readied for its first reading on the floor. Bills may be introduced in either chamber until the last 35 days of the session. After that, bills may be introduced only with the consent of two-thirds of the membership.

First reading. The reading clerk, when the session has convened, reads the title, and the presiding officer assigns the bill to the appropriate committee.

Reference to committee. The committees meet daily during the session to receive testimony and take action on bills assigned. Citizens are encouraged to present their views on the subject matter by mail or by personal appearance. Legislative agents (lobbyists), representing organized interest groups, speak at these hearings, either to oppose or support the proposed legislation. The Department of Fiscal Services prepares a fiscal analysis for each bill and these fiscal notes are considered during the committee deliberation.

Unfavorable committee action, which may mean legislative death, frequently requires as much, or more, committee discussion and time as favorable committee action, which sends the bill to the floor for second reading and floor consideration.

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Med Chi main office

1211 Cathedral Street
Baltimore, MD 21201-5585
410-539-0872
1-800-492-1056
FAX 410-547-0915

Med Chi legislative office

224 Main Street
Annapolis, MD 21204
410-263-4035
Fax: 410-263-4207

Second reading and floor consideration. The bill is reported to the floor by the committee (favorably, unfavorably, or without recommendation, and with or without committee amendment). It is open to amendment from the floor, and the ultimate form of the bill must be determined on second reading. Committee action may be reversed but this is infrequent.

Third reading. The bill must be printed for third reading with all amendments included in this final version. No amendments may be presented on third reading in the chamber of its origin, and the bill must be passed by a majority of the elected membership.

Second chamber. The procedure follows a pattern identical with that of the chamber in which the bill originated, except amendments may be proposed during third reading as well as second reading. If not amended in the second chamber, final passage may occur without reprinting.

State legislative directory — Consideration and progress of bills

Consideration of bills*

Consideration of bills originating in one chamber and amended in second chamber

If amended in the second chamber, the bill is returned to the chamber of origin where a vote is taken on a motion to concur or reject the amendments. If concurrence is voted, the bill itself is voted on as amended and action is complete. The bill is reprinted, or enrolled, to include the added amendments before submitting it to the governor.

If the amendments are rejected, two courses of action are possible: (1) the amending chamber may be requested to withdraw its amendments or (2) upon refusal of withdrawal of amendments, either chamber may request a conference committee to resolve the differences between the two chambers.

Conference committee. A report of a conference committee goes back to both chambers to be adopted or rejected without amendment. If the conference committee report is adopted, the bill is voted upon for final passage in each house. If the conference committee report is rejected by either house, the bill fails.

Presentation of bills to the governor.

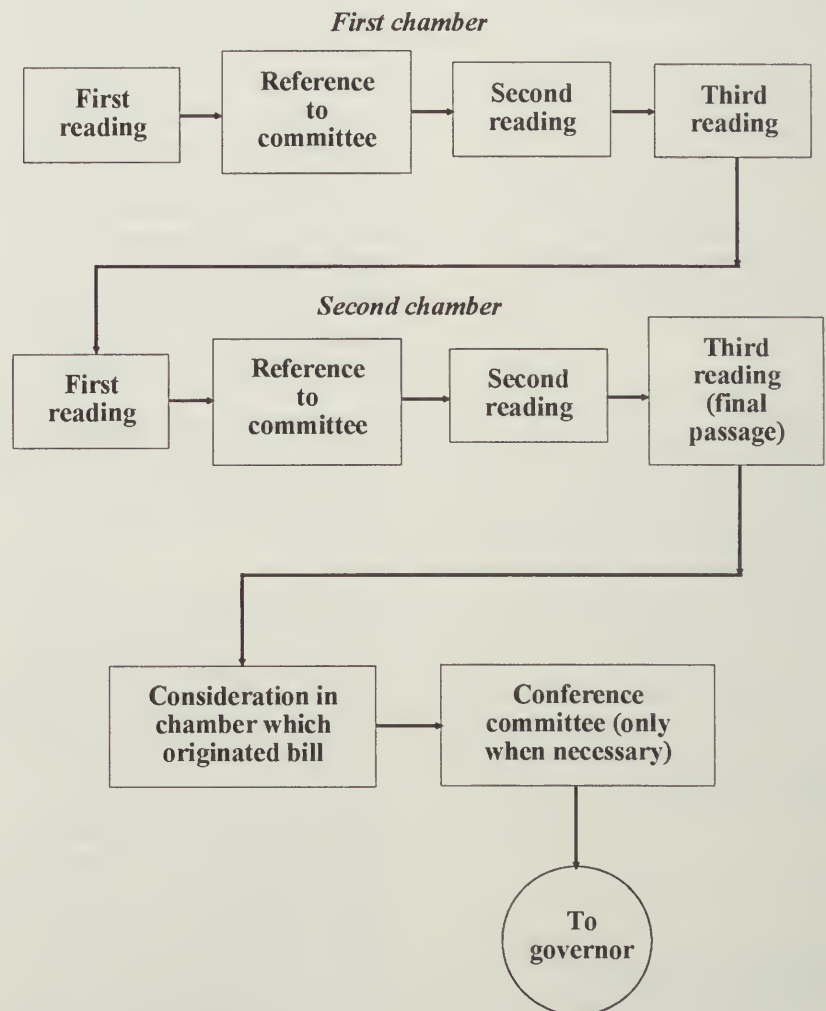
Presentation of all bills to the governor is mandatory, except the budget bill and constitutional amendments. The budget bill becomes law upon its final passage and cannot be vetoed. Bills must be presented to the governor within 20 days following adjournment of a session, and in the case of such bills, the governor may veto within 30 days after presentation to him or her. If a bill is not vetoed, it becomes a law. The governor may not veto a constitutional amendment.

The power to override a veto. This power rests with the legislature. If a

bill is vetoed during regular session, the veto message is considered immediately. If a bill presented after the session is vetoed, the veto message must be considered immediately at the next regular or

special session of the legislature, except that the legislature may not override a veto during the first year of a new term. A three-fifths vote of the elected membership in each chamber is necessary to override a veto.

The progress of a bill*



* Information provided by Carvel Payne, director, Maryland Department of Legislative Reference.

State legislative directory — Dates of interest, telephone numbers

The 1993 Maryland General Assembly —Dates of interest*

January 13	General assembly convenes (noon, Wednesday).
To be announced	Governor delivers State of the State address.
January 20	Final date for governor to introduce budget bill.
January 22	Final date for submission of executive orders reorganizing the executive branch of state government. Either House may disapprove by resolution within 50 days. Administration bills introduced after this date are referred to the Senate Rules Committee.
January 26	Senate bill and House bill request guarantee date. (All bills filed by this date <i>must</i> be considered by committee.)
February 1	Final date for governor to introduce capital budget bill Final date for submission of evaluation committee reports of governmental activities or units designated for program evaluation.
February 5	Senate and House bill introduction date. Senate bills introduced after this date are referred to the Senate Rules Committee. House bill introduction courtesy date.
February 26	House bills introduced after this date are referred to the House Rules Committee. (They are not guaranteed to have public committee hearings.)
March 8	Final date for introduction of bills without suspension of rules.
March 23	Committee reporting courtesy date Each chamber's committees should report out their own bills by this date.
March 29	Opposite chamber bill crossover date. Each chamber should send to the other chamber those bills it intends to pass favorably. Opposite chamber bills received after this date are subject to referral to the rules committee.
April 5	Budget bill to be passed by both chambers by this date.
April 12	Adjournment.
May 12	Final date for an extended session.

Post-session

May 2	Final date for presentment of bills to the governor.
June 1	Other than emergency bills, earliest date for bills to take effect. Governor to sign/veto bills by this date.
July 1	Budget, tax, and revenue bills to take effect.
October 1	Usual effective date for bills.

*Courtesy of Department of Legislative Reference

The 1993 Maryland General Assembly — Important telephone numbers

Calling the extensions below is a local call from the Baltimore & Washington areas—from the Baltimore area, dial the exchange 841; from the Washington area, dial the exchange 858. Outside the Baltimore/Washington area, call 1-800-492-7122.

<i>Legislative information & library</i>	ext. 3810
<i>Information desk, State House</i>	ext. 3886
<i>President of the Senate</i>	ext. 3700
<i>Thomas V. "Mike" Miller, Jr.</i>	
<i>Senate majority leader</i>	ext. 3697
<i>Clarence W. Blount</i>	
<i>Senate minority leader</i>	ext. 3568
<i>John A. Cade</i>	
<i>Senate Budget & Taxation Committee</i>	ext. 3690
<i>Senate Economic & Environmental Affairs Committee</i>	ext. 3661
<i>Senate Finance Committee</i>	ext. 3677
<i>Senate Judicial Proceedings Committee</i>	ext. 3623
<i>Speaker of the House of Delegates</i>	ext. 3800
<i>R. Clayton Mitchell, Jr.</i>	
<i>House majority leader</i>	ext. 3464
<i>R. Bruce Poole</i>	
<i>House minority leader</i>	ext. 3401
<i>Ellen R. Sauerbrey</i>	
<i>House Committee on Appropriations</i>	ext. 3407
<i>House Committee on Economic Matters</i>	ext. 3519
<i>House Committee on Environmental Matters</i>	ext. 3534
<i>House Judiciary Committee</i>	ext. 3488
<i>House Committee on Ways and Means</i>	ext. 3469
<i>Bill room (copies of bills, amendments, and fiscal notes)</i>	ext. 3840

State legislative directory — Senate standing committees

Calling the extensions below is a local call from the Baltimore & Washington areas—from the Baltimore area, dial the exchange 841; from the Washington area, dial the exchange 858. Outside the Baltimore/Washington area, call 1-800-492-7122.

* = indicates new committee member

Senate Finance Committee

*Room P.W., Senate Office Bldg.,
Annapolis, MD 21401-1991
Telephone — ext. 3677*

Chairperson: *Thomas P. O'Reilly*, Prince George's County (22)

Vice Chairperson: *James C. Simpson*, Charles and St. Mary's counties (28)

Members

F. Vernon Boozer, Baltimore County (9)
Thomas L. Bromwell, Baltimore County (8)
George W. Della, Jr., Baltimore City (47)
John W. Derr, Frederick and Washington counties (3)
Leo E. Green, Prince George's County (23)
John J. Hafer, Allegany and Garrett counties (1)
Patricia R. Sher, Montgomery County (18)
Michael J. Wagner, Anne Arundel County (32)
Larry Young, Baltimore City (39)

Staff contact: *Steve Ports*

Assistant to chairperson: *Kathleen Smith*

Senate Judicial Proceedings Committee

*Room 300, Senate Office Bldg.,
Annapolis, MD 21401-1991
Telephone — ext. 3623*

Chairperson: *Walter M. Baker*, Caroline, Cecil, Kent, Queen Anne's, and Talbot counties (36)

Vice Chairperson: *Norman R. Stone, Jr.*, Baltimore County (7)

Members

Mary H. Boergers, Montgomery County (17)
Howard A. Denis, Montgomery County (16)
Habern Freeman, Harford County (34)
Larry E. Haines, Carroll and Baltimore counties (5)
Ralph M. Hughes, Baltimore City (40)
Philip C. Jimeno, Anne Arundel County (31)
Frederick C. Malkus, Jr., Caroline, Dorchester, Talbot, and Wicomico counties (37)
John A. Pica, Jr., Baltimore City (43)
Janice Piccinini, Baltimore County (10)

Staff contact: *Susan H. Russell*, *Kathleen M. Boucher*

Assistant to chairperson: *Jean Stahl*

Senate Economic and Environmental Affairs Committee

*Room 200, Senate Office Bldg.,
Annapolis, MD 21401-1991
Telephone — ext. 3661*

Chairperson: *Clarence W. Blount*, Baltimore City (41)

Vice Chairperson: *Arthur Dorman*, Prince George's County (21)

Members

Michael J. Collins, Baltimore County (6)
C. Bernard Fowler, Anne Arundel, Calvert, and St. Mary's counties (29)
Idamae Garrott, Montgomery County (19)
Paula C. Hollinger, Baltimore County (11)
Gloria Lawlah, Prince George's County (26)
Christopher J. McCabe, Howard and Montgomery counties (14)
American Joe Miedusiewski, Baltimore City (46)
J. Lowell Stoltzfus, Somerset, Worcester, and Wicomico counties (38)
Gerald W. Winegrad, Anne Arundel County (30)

Staff contact: *Carol L. Swan*, *Lynne S. Blume*

Assistant to chairperson: *Bobbi Jo Schwartz*

Senate Budget and Taxation Committee

*Room 132 Senate Office Bldg.,
Annapolis 21401-1991
ext. 3690*

Chairperson: *Laurence Levitan*, Montgomery County (15)

Vice Chairperson: *Barbara A. Hoffman*, Baltimore City (42)

Members

William H. Amoss, Harford and Cecil counties (35)
John A. Cade, Anne Arundel County (33)
Nathan C. Irby, Jr., Baltimore City (45)
Julian L. Lapidus, Baltimore City (44)
Donald F. Munson, Allegany and Washington counties (2)
Nancy L. Murphy, Baltimore County (12)
Ida G. Ruben, Montgomery County (20)
Charles H. Smelser, Frederick, Carroll and Howard counties (4)
Decatur W. Trotter, Prince George's County (24)
Albert R. Wynn, Prince George's County (25)
Thomas M. Yeager, Howard and Prince George's counties (13)

Staff contact: *Doug Mann*

Assistant to chairperson: *Toni Bosworth*

State legislative directory — House standing committees

Calling the extensions below is a local call from the Baltimore & Washington areas—from the Baltimore area, dial the exchange 841; from the Washington area, dial the exchange 858. Outside the Baltimore/Washington area, call 1-800-492-7122.

* = indicates new committee member

House Committee on Appropriations

*Room 130, House Office Bldg.,
Annapolis, 21401-1991
Telephone - ext. 3407*

Chairperson: *Howard P. Rawlings*, Baltimore City (40)

Vice Chairperson: *James E. McClellan*, Washington and Frederick counties (3B)

Members

John C. Astle, Anne Arundel County (30)
R. Charles Avara, Baltimore City (47)
Joseph Bartenfelder, Baltimore County (8)
Joan Cadden, Anne Arundel County* (31)
Norman H. Conway, Somerset, Worcester and Wicomico counties (38)
Ulysses Currie, Prince George's County (25)
Thomas E. Dewberry, Baltimore County (12)
Richard N. Dixon, Carroll and Baltimore counties (5A)
George C. Edwards, Garrett and Allegany counties (1A)
Robert L. Flanagan, Montgomery and Howard counties (14B)
Jennie M. Forehand, Montgomery County (17)
Peter Franchot, Montgomery County (20)
Donald C. Fry, Harford and Cecil counties* (35A)
John G. Gary, Anne Arundel County (33)
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Martha S. Klima, Baltimore County (9)
Nancy K. Kopp, Montgomery County (16)
Timothy F. Maloney, Prince George's County (21)
Ethel Ann Murray, Harford and Cecil counties (35B)
Richard A. Palumbo, Prince George's County (22)
Samuel M. Parham, Baltimore City* (41)
D. Bruce Poole, Washington and Frederick counties* (3A)
James E. Proctor, Jr., Prince George's County * (27)
Samuel I. Rosenberg, Baltimore City (42)
Richard Rynd, Baltimore County (11)
Ellen R. Sauerbrey, Baltimore County* (10)
John F. Slade III, Calvert, St. Mary's, and Anne Arundel counties (29C)
Christopher Van Hollen, Jr., Montgomery County* (18)
Staff contact: *Melanie Wenger*, Richard Madaleno
Assiatant to chairperson: *Peg McCloskey*

House Committee on Economic Matters

*Room 151, House Office Bldg.,
Annapolis, MD 21401-1991
Telephone — ext. 3519*

Chairperson: *Casper R. Taylor, Jr.*, Allegany and Washington counties (2A)

Vice Chairperson: *Gary R. Alexander*, Prince George's County (27)

Members

Leon Albin, Baltimore County (11)
Kumar P. Barve, Montgomery County (17)
K. Bennett Bozman, Somerset, Wicomico, and Worcester counties* (38)
Michael E. Busch, Anne Arundel County (30)
Elijah E. Cummings, Baltimore City* (39)
Gerald J. Curran, Baltimore City (43)
John P. Donoghue, Washington County (2C)
Ann Marie Doory, Baltimore City (43)
Nathaniel Exum, Pringe George's County (24)
Connie C. Galiazzo, Baltimore County* (7)
Hattie N. Harrison, Baltimore City (45)
John Adams Hurson, Montgomery County (18)
Christine M. Jones, Prince George's County (26)
A. Wade Kach, Baltimore County (10)
Ruth M. Kirk, Baltimore City (39)
Robert H. Kittleman, Howard County (14B)
Charles W. Kolodziejski, Anne Arundel County (31)
Carolyn Krysiak, Baltimore City* (46)
Richard LaVay, Montgomery County (15)
George H. Littrell, Jr., Frederick County (4A)
Martin G. Madden, Howard and Prince George's counties (13B)
Charles A. McClenahan, Frederick and Washington counties (38)
Maggie Lee Ann McIntosh, Baltimore City* (44)
Louis P. Morsberger, Baltimore City (12)
Patrick C. Scannello, Anne Arundel County (32)
John F. Wood, Jr., Charles and St. Mary's counties (28)
Staff contact: *Lars B. Kristiansen*, *Donna Imhoff*, and *Elizabeth Sammis*
Assistant to chairperson: *Nancy Collins*

State legislative directory — House standing committees

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* = indicates new committee member

House Committee on Environmental Matters

*Room 161, House Office Bldg.,
Annapolis, MD 21401-1991
Telephone — ext. 3534*

Chairperson: *Ronald A. Guns*, Caroline, Cecil, Kent, and Queen Anne's counties (36)

Vice Chairperson: *Virginia M. Thomas*, Howard County (13A)

Members

Leon G. Billings, Montgomery County* (18)
RoseMary Hatem Bonsack, Harford County (34)
Stephen J. Braun, Charles County* (28A)
Peter G. Callas, Washington County* (2B)
Anthony M. DiPietro, Jr., Baltimore City (46)
Donald B. Elliott, Carroll and Howard counties (4B)
Brian E. Frosh, Montgomery County (16)
James W. Hubbard, Prince George's County (23)
John D. Jefferies, Baltimore City (39)
Samuel Q. Johnson III, Caroline, Dorchester, Talbot, and Wicomico counties (37)
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David M. Valderrama, Prince George's County (26)
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Staff contact: *Robert K. Smith, Pegeen Townsend*

Assistant to chairperson: *Christine Seabolt*

House Judiciary Committee

*Room 120, House Office Bldg.,
Annapolis, MD 21401-1991
Telephone — ext. 3488*

Chairperson: *John S. Arnick*, Baltimore County (7)

Vice Chairperson: *Joel Chasnoff*, Montgomery County (14A)

Members

Curtis S. Anderson, Baltimore City (44)
Michael Arrington II, Prince George's County (25)
J. Ernest Bell II, Calvert and St. Mary's counties (29B)
Joanne C. Benson, Prince George's County* (24)
Phillip D. Bissett, Anne Arundel County (30)
Rosa Lee Blumenthal, Prince George's County (26)
Frank D. Boston, Jr., Baltimore City (41)
Gerry L. Brewster, Baltimore County (9)
Dana Lee Dembrow, Montgomery County* (20)
Cornell N. Dypski, Baltimore City (46)
Robert L. Ehrlich, Jr., Baltimore County (10)
C. Ronald Franks, Caroline, Cecil, Kent, Queen Anne's, and Talbot counties* (36)
Tony E. Fulton, Baltimore City* (40)
Gilbert J. Genn, Montgomery County (16)
James M. Harkins, Harford and Cecil counties (35A)
Leslie E. Hutchinson, Baltimore County* (6)
Kevin Kelly, Garrett and Allegany counties (1B)
E. Farrell Maddox, Baltimore County (6)
Kenneth H. Masters, Baltimore County (12)
Richard C. Matthews, Carroll County (5A)
Pauline H. Menes, Prince George's County (21)
Kenneth C. Montague, Jr., Baltimore City (44)
Carol S. Petzold, Montgomery County* (19)
Mary Louise Preis, Harford County (34)
Joseph F. Vallario, Jr., Prince George's County (27)
Betty Workman, Allegany County* (1B)

Staff contact: *Douglas R. Nester, Donald J. Hogan*

Assistant to chairperson: *Mary Jane Wallop*

State legislative directory — House standing committees

Calling the extensions below is a local call from the Baltimore & Washington areas—from the Baltimore area, dial the exchange 841; from the Washington area, dial the exchange 858. Outside the Baltimore/Washington area, call 1-800-492-7122.

* = indicates new committee member

House Committee on Ways and Means

*Room 100, House of Delegates Bldg.,
Annapolis 21401-1991
ext. 3469*

Chairperson: *Tyras S. Athey*, Anne Arundel County (32)

Vice Chairperson: *Gene W. Counihan*, Montgomery County (15)

Members

John J. Bishop, Baltimore County (9)
James W. Campbell, Baltimore City (42)
Mary A. Conroy, Prince George's County (23)
David R. Craig, Harford County* (34)
Clarence Davis, Baltimore City (45)
Louis L. DePazzo, Baltimore County (7)
John W. Douglass, Baltimore City* (45)
Michael R. Gordon, Montgomery County (17)
Thomas H. Hattery, Frederick, Carroll, and Howard counties (4A)
Anne Healey, Prince George's County (22)
Henry B. Heller, Montgomery County (19)
Sheila Ellis Hixson, Montgomery County (20)
Carolyn J.B. Howard, Prince George's County* (24)
W. Ray Huff, Anne Arundel County* (31)
Theodore Levin, Baltimore County (11)
Salima Siler Marriott, Baltimore City (40)
John S. Morgan, Howard and Prince George's counties * (13B)
James F. Ports, Baltimore County * (8)
James C. Rosapepe, Prince George's County (21)
Elizabeth S. Smith, Anne Arundel County (33)
Michael J. Sprague, Charles and St. Mary's counties (28A)
Robert A. Thornton, Jr., Dorchester, Caroline, Talbot, and Wicomico counties (37)
Beatrice P. Tignor, Prince George's County (25)
Paul E. Weisengoff, Baltimore City (47)

Staff contact: *Lee Smith-Sera, Michael Sanderson*

Assistant to chairperson: *Betty Anne O'Neill*

Maryland General Assembly members, 1993—By legislative district

Legislative district 1

Garrett, Allegany counties

Sen. John J. Hafer
Del. George C. Edwards (1A)
Del. Kevin Kelly (1B)
Del. Betty Workman (1B)

Legislative district 2

Allegany, Washington counties

Sen. Donald F. Munson
Del. Peter G. Callas (2B)
Del. John P. Donoghue (2C)
Del. Casper R. Taylor, Jr. (2A)

Legislative district 3

Washington, Frederick counties

Sen. John W. Derr
Del. James E. McClellan (3B)
Del. D. Bruce Poole (3A)
Del. J. Anita Stup (3B)

Legislative district 4

Frederick, Carroll, Howard counties

Sen. Charles H. Smelser
Del. Donald B. Elliott (4B)
Del. Thomas H. Hattery (4A)
Del. George H. Littrell, Jr. (4A)

Legislative district 5

Carroll, Baltimore counties

Sen. Larry E. Haines
Del. Richard N. Dixon (5A)
Del. Lawrence A. LaMotte (5B)
Del. Richard C. Matthews (5A)

Legislative district 6

Baltimore county

Sen. Michael J. Collins
Del. Leslie E. Hutchinson
Del. E. Farrell Maddox
Del. Michael H. Weir

Maryland General Assembly members, 1993—By legislative district

Legislative district 7

Baltimore County

Sen. Norman R. Stone, Jr.
Del. John S. Arnick
Del. Louis L. DePazzo
Del. Connie C. Galiazso

Legislative district 8

Baltimore County

Sen. Thomas L. Bromwell
Del. Joseph Bartenfelder
Del. James F. Ports
Del. Alfred W. Redmer, Jr.

Legislative district 9

Baltimore County

Sen. F. Vernon Boozer
Del. John J. Bishop
Del. Gerry L. Brewster
Del. Martha S. Klima

Legislative district 10

Baltimore County

Sen. Janice Piccinini
Del. Robert L. Ehrlich, Jr.
Del. A. Wade Kach
Del. Ellen R. Sauerbrey

Legislative district 11

Baltimore County

Sen. Paula C. Hollinger
Del. Leon Albin
Del. Theodore Levin
Del. Richard Rynd

Legislative district 12

Baltimore County

Sen. Nancy L. Murphy
Del. Thomas E. Dewberry
Del. Kenneth H. Masters
Del. Louis P. Morsberger

Legislative district 13

Howard, Prince George's counties

Sen. Thomas M. Yeager
Del. Martin G. Madden (13B)
Del. John S. Morgan (13B)
Del. Virginia M. Thomas (13A)

Legislative district 14

Montgomery, Howard counties

Sen. Christopher J. McCabe
Del. Joel Chasnoff (14A)
Del. Robert L. Flanagan (14B)
Del. Robert H. Kittleman (14B)

Legislative district 15

Montgomery County

Sen. Laurence Levitan
Del. Gene W. Counihan
Del. Richard LaVay
Del. Jean W. Roesser

Legislative district 16

Montgomery County

Sen. Howard A. Denis
Del. Brian E. Frosh
Del. Gilbert J. Genn
Del. Nancy K. Kopp

Legislative district 17

Montgomery County

Sen. Mary H. Boergers
Del. Kumar P. Barve
Del. Jennie M. Forehand
Del. Michael R. Gordon

Legislative district 18

Montgomery County

Sen. Patricia R. Sher
Del. Leon G. Billings
Del. John Adams Hurson
Del. Christopher Van Hollen, Jr.

Legislative district 19

Montgomery County

Sen. Idamae Garrott
Del. Henry B. Heller
Del. Carol S. Petzold
Del. Leonard H. Teitelbaum

Legislative district 20

Montgomery County

Sen. Ida G. Ruben
Del. Dana Lee Dembrow
Del. Peter Franchot
Del. Sheila Ellis Hixson

Legislative district 21

Prince George's County

Sen. Arthur Dorman
Del. Timothy F. Maloney
Del. Pauline H. Menes
Del. James C. Rosapepe

Legislative district 22

Prince George's County

Sen. Thomas P. O'Reilly
Del. Anne Healey
Del. Richard A. Palumbo
Del. Paul G. Pinsky

Legislative district 23

Prince George's County

Sen. Leo E. Green
Del. Mary A. Conroy
Del. James W. Hubbard
Del. Joan B. Pitkin

Legislative district 24

Prince George's County

Sen. Decatur W. Trotter
Del. Joanne C. Benson
Del. Nathaniel Exum
Del. Carolyn J.B. Howard

Legislative district 25

Prince George's County

Sen. Albert R. Wynn
Del. Michael Arrington II
Del. Ulysses Currie
Del. Beatrice P. Tignor

Legislative district 26

Prince George's County

Sen. Gloria Lawlah
Del. Rosa Lee Blumenthal
Del. Christine M. Jones
Del. David M. Valderrama

Legislative district 27

Prince George's County

Sen. Thomas V. "Mike" Miller, Jr.
Del. Gary R. Alexander
Del. James E. Proctor, Jr.
Del. Joseph F. Vallario, Jr.

Maryland General Assembly members, 1993—By legislative district

Legislative district 28

Charles, St. Mary's counties

Sen. James C. Simpson
Del. Stephen J. Braun (28A)
Del. Michael J. Sprague (28A)
Del. John F. Wood, Jr. (28B)

Legislative district 29

Calvert, St. Mary's, Anne Arundel counties

Sen. C. Bernard Fowler
Del. J. Ernest Bell II (29B)
Del. George W. Owings III (29A)
Del. John F. Slade III (29C)

Legislative district 30

Anne Arundel County

Sen. Gerald W. Winegrad
Del. John C. Astle
Del. Phillip D. Bissett
Del. Michael E. Busch

Legislative district 31

Anne Arundel County

Sen. Philip C. Jimeno
Del. Joan Cadden
Del. W. Ray Huff
Del. Charles W. Kolodziejewski

Legislative district 32

Anne Arundel County

Sen. Michael J. Wagner
Del. Tyras S. Athey
Del. Patrick C. Scannello
Del. Victor A. Sulin

Legislative district 33

Anne Arundel County

Sen. John A. Cade
Del. John G. Gary
Del. Marsha G. Perry
Del. Elizabeth S. Smith

Legislative district 34

Harford County

Sen. Habern Freeman
Del. RoseMary Hatem Bonsack
Del. David R. Craig
Del. Mary Louise Preis

Legislative district 35

Harford, Cecil counties

Sen. William H. Amoss
Del. Donald C. Fry (35A)
Del. James M. Harkins (35A)
Del. Ethel A. Murray (35B)

Legislative district 36

Kent, Queen Anne's, Cecil, Caroline, Talbot counties

Sen. Walter M. Baker
Del. C. Ronald Franks
Del. Ronald A. Guns
Del. R. Clayton Mitchell, Jr.

Legislative district 37

Dorchester, Caroline, Talbot, Wicomico counties

Sen. Frederick C. Malkus, Jr.
Del. Samuel Q. Johnson III
Del. Kenneth D. Schisler
Del. Robert A. Thornton, Jr.

Legislative district 38

Somerset, Worcester, Wicomico counties

Sen. J. Lowell Stoltzfus
Del. K. Bennett Bozman
Del. Norman H. Conway
Del. Charles McClenahan

Legislative district 39

Baltimore City

Sen. Larry Young
Del. Elijah E. Cummings
Del. John D. Jefferies
Del. Ruth M. Kirk

Legislative district 40

Baltimore City

Sen. Ralph M. Hughes
Del. Tony E. Fulton
Del. Salima Siler Marriott
Del. Howard P. Rawlings

Legislative district 41

Baltimore City

Sen. Clarence W. Blount
Del. Frank D. Boston, Jr.
Del. Margaret H. Murphy
Del. Samuel M. Parham

Legislative district 42

Baltimore City

Sen. Barbara A. Hoffman
Del. James W. Campbell
Del. Delores G. Kelley
Del. Samuel I. Rosenberg

Legislative district 43

Baltimore City

Sen. John A. Pica, Jr.
Del. Gerald J. Curran
Del. Ann Marie Doory
Del. Henry R. Hergenroeder, Jr.

Legislative district 44

Baltimore City

Sen. Julian L. Lapides
Del. Curtis S. Anderson
Del. Maggie Lee Ann McIntosh
Del. Kenneth C. Montague, Jr.

Legislative district 45

Baltimore City

Sen. Nathan C. Irby, Jr.
Del. Clarence Davis
Del. John W. Douglass
Del. Hattie N. Harrison

Legislative district 46

Baltimore City

Sen. American Joe Miedusiewski
Del. Anthony M. DiPietro, Jr.
Del. Cornell N. Dypski
Del. Carolyn J. Krysiak

Legislative district 47

Baltimore City

Sen. George W. Della, Jr.
Del. R. Charles Avara
Del. Brian K. McHale
Del. Paul E. Weisengoff

**Maryland General Assembly, 1993 —
Members of the Senate, alphabetically with addresses**

Amoss, William H. (*Dist. 35*)
Session address 401 Senate Office Bldg.
 Annapolis 21401-1991
 ext. 3603
District address 2303 Bel Air Rd.
 P.O. Box 496
 Fallston 21047-0496
 410-879-7272
Member since 1983 (House 1975-1982)

Baker, Walter M. (*Dist. 36*)
Session address 301 Senate Office Bldg.
 Annapolis 21401-1991
 ext. 3639
District address 153 East Main St.
 Elkton 21921-5975
 410-398-0980
Member since 1979

Blount, Clarence W. (*Dist. 41*)
Session address 201 Senate Office Bldg.
 Annapolis 21401-1991
 ext. 3697
District address 4811 Liberty Heights Ave.
 Baltimore 21207
 410-466-1197
Member since 1971

Boergers, Mary H. (*Dist. 17*)
Session address 208 Senate Office Bldg.
 Annapolis 21401-1991
 ext. 3134
District address 4417 Puller Dr.
 Kensington 20895
 301-564-0508
Member since 1991 (House 1981-1990)

Boozer, F. Vernon (*Dist. 9*)
Session address 410 Senate Office Bldg.
 Annapolis 21401-1991
 ext. 3706
District address 614 Bosley Ave.
 Towson 21204-4066
 410-828-0669
Member since 1981 (House 1971-1979)

Bromwell, Thomas L. (*Dist. 8*)
Session address 215 Senate Office Bldg.
 Annapolis 21401-1991
 ext. 3620
District address 215 Senate Office Bldg.
 Annapolis 21401-1991
 ext. 3620
Member since 1983 (House 1979-1983)

Cade, John A. (*Dist. 33*)
Session address 407 Senate Office Bldg.
 Annapolis 21401-1991
 ext. 3568
District address 407 Senate Office Bldg.
 Annapolis 21401-1991
 ext. 3568
Member since 1975

Collins, Michael J. (*Dist. 6*)
Session address 211 Senate Office Bldg.
 Annapolis 21401-1991
 ext. 3642
District address 418 Eastern Blvd.
 Baltimore 21221-6786
 410-391-7800
Member since 1986 (House 1978-1986)

Della, George W., Jr. (*Dist. 47*)
Session address 207 Senate Office Bldg.
 Annapolis 21401-1991
 ext. 3600
District address 801 Light St., 2nd floor
 Baltimore 21230-3912
 410-244-8400
Member since 1983

Denis, Howard A. (*Dist. 16*)
Session address 402B Senate Office Bldg.
 Annapolis 21401-1991
 ext. 3124
District address 402B Senate Office Bldg.
 Annapolis 21401-1991
 ext. 3124
Member since 1977

Derr, John W. (*Dist. 3*)
Session address 408 Senate Office Bldg.
 Annapolis 21401-1991
 ext. 3575
District address 13 West Second St.
 Frederick 21701-5326
 301-695-5733
Member since 1983

Dorman, Arthur (*Dist. 21*)
Session address 303 Senate Office Bldg.
 Annapolis 21401-1991
 ext. 3141
District address 303 Senate Office Bldg.
 Annapolis 21401-1991
 ext. 3141
Member since 1975 (House 1965-1975)

Fowler, C. Bernard (*Dist. 29*)
Session address 210 Senate Office Bldg.
 Annapolis 21401-1991
 ext. 3673
District address P.O. Box 459
 Prince Frederick 20678-0459
 410-535-3366
Member since 1983

Freeman, Habern (*Dist. 34*)
Session address 202 Senate Office Bldg.
 Annapolis 21401-1991
 ext. 3158
District address 2208 Old Emmorton Rd.
 Ste. 102
 Bel Air 21014
 410-515-1603
Member since 1991

Garrott, Idamae (*Dist. 19*)
Session address 304 Senate Office Bldg.
 Annapolis 21401-1991
 ext. 3151
District address 304 Senate Office Bldg.
 Annapolis 21401-1991
 ext. 3151
Member since 1987 (House 1979-1987)

Green, Leo E. (*Dist. 23*)
Session address 212 Senate Office Bldg.
 Annapolis 21401-1991
 ext. 3631
District address 3123 Belair Drive
 Bowie 20715-3198
 301-464-8777
Member since 1983 (House 1975-1979)

Hafer, John J. (*Dist. 1*)
Session address 406 Senate Office Bldg.
 Annapolis 21401-1991
 ext. 3565
District address 58 Frost Ave.
 P.O. Box 116
 Frostburg 21532-0116
 301-689-4666
Member since 1991

Haines, Larry E. (*Dist. 5*)
Session address 403 Senate Office Bldg.
 Annapolis 21401-1991
 ext. 3683
District address 532 Baltimore Blvd.
 Westminster 21157
 410-876-4530
Member since 1991

Calling your representatives in Annapolis is a local call from the Baltimore & Washington areas—from the Baltimore area, dial the exchange 841; from the Washington area, dial the exchange 858. Outside the Baltimore/Washington areas, call 1-800-492-7122.

**Maryland General Assembly, 1993 —
Members of the Senate, alphabetically with addresses**

Hoffman, Barbara A. (Dist. 42)
Session 100 Senate Office Bldg.
address Annapolis 21401-1991
 ext. 3648

District 6615 Reisterstown Rd.
address Ste. 301
 Baltimore 21215-2603
 410-764-3614
Member
since 1983

Hollinger, Paula Colodny (Dist. 11)
Session 206 Senate Office Bldg.
address Annapolis 21401-1991
 ext. 3131

District 206 Senate Office Bldg.
address Annapolis 21401-1991
 ext. 3131
Member
since 1987 (House 1979-1987)

Hughes, Ralph M. (Dist. 40)
Session 310 Senate Office Bldg.
address Annapolis 21401-1991
 ext. 3656

District 2320 North Monroe St.
address Baltimore 21217-1398
 410-225-0555
Member
since 1991 (House 1983-1990)

Irby, Nathan C., Jr. (Dist. 45)
Session 214 Senate Office Bldg.
address Annapolis 21401-1991
 ext. 3165

District 2021 East Biddle St.
address Baltimore 21213-3345
 410-675-3000
Member
since 1983

Jimeno, Philip C. (Dist. 31)
Session 305 Senate Office Bldg.
address Annapolis 21401-1991
 ext. 3658

District 5915 Manor House Lane
address Baltimore 21225-3359
 410-636-4134
Member
since 1985 (House 1979-1985)

Lapides, Julian L. (Dist. 44)
Session 116 Senate Office Bldg.
address Annapolis 21401-1991
 ext. 3686

District 807 Cathedral St.
address Baltimore 21201-5281
 410-752-4519
Member
since 1967 (House 1963-1967)

Lawlah, Gloria (Dist. 26)
Session 307 Senate Office Bldg.
address Annapolis 21401-1991
 ext. 3092

District 3801 24th Ave.
address Hillcrest Heights 20748
 301-894-3082
Member
since 1991 (House 1987-1990)

Levitan, Laurence (Dist. 15)
Session 100 Senate Office Bldg.
address Annapolis 21401-1991
 ext. 3169

District 100 Senate Office Bldg.
address Annapolis 21401-1991
 ext. 3169
Member
since 1975 (also 1971-1974)

Malkus, Frederick C., Jr. (Dist. 37)
Session PW Senate Office Bldg.
address Annapolis 21401-1991
 ext. 3590

District 500 Spring St.
address P.O. Box 316
 Cambridge 21613-0316
 410-228-1911
Member
since 1951 (House 1947-1951)

McCabe, Christopher J. (Dist. 14)
Session 404 Senate Office Bldg.
address Annapolis 21401-1991
 ext. 3671

District 12400 Clarksville Pike
address Clarksville 21029-1225
 410-988-9818
Member
since 1991

Miedusiewski, American Joe (Dist. 46)
Session 311 Senate Office Bldg.
address Annapolis 21401-1991
 ext. 3598

District 421 South Highland Ave.
address Baltimore 21224-2314
 410-276-8225
Member
since 1988 (House 1975-1988)

Miller, Thomas V. "Mike," Jr. (Dist. 27)
Session H107 State House
address Annapolis 21401-1991
 ext. 3700

District H107 State House
address Annapolis 21401-1991
 ext. 3700
Member
since 1975 (House 1971-1975)

Munson, Donald F. (Dist. 2C)
Session 405 Senate Office Bldg.
address Annapolis 21401-1991
 ext. 3609

District 28 West Church St.
address Hagerstown 21740-4808
 301-791-4511
Member
since 1991 (House 1975-1990)

Murphy, Nancy L. (Dist. 12)
Session 205 Senate Office Bldg.
address Annapolis 21401-1991
 ext. 3653

District 1330 Sulphur Spring Rd.
address 2nd fl.
 Baltimore 21227-2794
 410-242-5699
Member
since 1989 (House 1983-1989)

O'Reilly, Thomas Patrick (Dist. 22)
Session PW Senate Office Bldg.
address Annapolis 21401-1991
 ext. 3155

District 7219 Hanover Pkwy.
address Ste. C & D
 Greenbelt 20770
 301-345-6900
Member
since 1975

Pica, John A., Jr. (Dist. 43)
Session 402A Senate Office Bldg.
address Annapolis 21401-1991
 ext. 3145

District 402A Senate Office Bldg.
address Annapolis 21401-1991
 ext. 3145
Member
since 1983 (House 1979-1982)

Piccinini, Janice (Dist. 10)
Session 308 Senate Office Bldg.
address Annapolis 21401-1991
 ext. 3606

District 201 West Padonia Rd.
address Ste. 501
 Timonium 21093-2114
 410-666-2000
Member
since 1991

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**Maryland General Assembly, 1993 —
Members of the Senate, alphabetically with addresses**

Piccinini, Janice (Dist. 10)

Session address 308 Senate Office Bldg.
Annapolis 21401-1991
ext. 3606

District address 201 West Padonia Rd.
Ste. 501
Timonium 21093-2114
410-666-2000

Member since 1991

Ruben, Ida G. (Dist. 20)

Session address 204 Senate Office Bldg.
Annapolis 21401-1991
ext. 3634

District address 204 Senate Office Bldg.
Annapolis 21401-1991
ext. 3634

Member since 1987 (House 1975-1987)

Sher, Patricia R. (Dist. 18)

Session address PW Senate Office Bldg.
Annapolis 21401-1991
ext. 3137

District address PW Senate Office Bldg.
Annapolis 21401-1991
ext. 3137

Member since 1991 (House 1979-1990)

Simpson, James C. (Dist. 28)

Session address 316 Senate Office Bldg.
Annapolis 21401-1991
ext. 3616

District address P.O. Box 188
Waldorf 20604-0188
301-843-1882

Member since 1975

Smelser, Charles H. (Dist. 4)

Session address 100 Senate Office Bldg.
Annapolis 21401-1991
ext. 3704

District address 100 Senate Office Bldg.
Annapolis 21401-1991
ext. 3704

Member since 1967 (House 1955-1963)

Stoltzfus, J. Lowell (Dist. 38)

Session address 409 Senate Office Bldg.
Annapolis 21401-1991
ext. 3645

District address 30487 Broad St.
Princess Anne 21853-1211
410-651-3886

Member since 1992 (House 1992)

Stone, Norman R., Jr. (Dist. 7)

Session address 216 Senate Office Bldg.
Annapolis 21401-1991
ext. 3587

District address 6905 Dunmanway
Baltimore 21222-5194
410-288-5270

Member since 1967 (House 1963-1967)

Trotter, Decatur W. (Dist. 24)

Session address 313 Senate Office Bldg.
Annapolis 21401-1991
ext. 3148

District address 1891 Brightseat Road
Landover 20785
301-772-2800

Member since 1983 (House 1975-1979)

Wagner, Michael J. (Dist. 32)

Session address 209 Senate Office Bldg.
Annapolis 21401-1991
ext. 3593

District address Arundel Center North
Rm. 510
101 Crain Hwy., N.W.
Glen Burnie 21061-3060
410-760-6453

Member since 1983 (also 1977-1979)
(House 1975-1977)

Winegrad, Gerald W. (Dist. 30)

Session address 314 Senate Office Bldg.
Annapolis 21401-1991
ext. 3578

District address 314 Senate Office Bldg.
Annapolis 21401-1991
ext. 3578

Member since 1983 (House 1978-1983)

Wynn, Albert R. (Dist. 25)

Session address 302 Senate Office Bldg.
Annapolis 21401-1991
ext. 3127

District address 8700 Central Ave.
Ste. 306
Landover 20785-4831
301-350-5055

Member since 1987 (House 1983-1987)

Yeager, Thomas M. (Dist. 13)

Session address 309 Senate Office Bldg.
Annapolis 21401-1991
ext. 3572

District address 413 Main St.
Laurel 20707-4176
301-498-3400

Member since 1983

Young, Larry (Dist. 39)

Session address 306 Senate Office Bldg.
Annapolis 21401-1991
ext. 3612

District address 1716 McCulloh St.
Baltimore 21217-3434
410-523-6650

Member since 1988 (House 1975-1987)

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Maryland General Assembly, 1993 —

Members of the House, alphabetically with addresses

Albin, Leon (*Dist. 11*)

Session address 310 House Office Bldg.
Annapolis 21401-1991
ext. 3342

District address 6512 Edenvale Rd.
Baltimore 21209-2721
410-486-1365

Member since 1987

Alexander, Gary R. (*Dist. 27*)

Session address 151 House Office Bldg.
Annapolis 21401-1991
ext. 3085

District address Fort Washington Prof. Park
11414 Livingston Rd.
Fort Washington 20744-5146
301-292-3300

Member since 1983

Anderson, Curtis S. (*Dist. 44*)

Session address 301 House Office Bldg.
Annapolis 21401-1991
ext. 3259

District address 2225 St. Paul St.
Baltimore 21218-5806
410-467-4444

Member since 1983

Arnack, John S. (*Dist. 7*)

Session address 121 House Office Bldg.
Annapolis 21401-1991
ext. 3488

District address 7918 Diehlwood Rd.
Dundalk 21222-3316
410-285-2109

Member since 1983 (1967-1979)

Arrington, Michael, II (*Dist. 25*)

Session address 203 House Office Bldg.
Annapolis 21401-1991
ext. 3076

District address 642 Mt. Lubentia Ct. E
Largo 20772
410-841-3076

Member since 1991

Astle, John C. (*Dist. 30*)

Session address 212 House Office Bldg.
Annapolis 21401-1991
ext. 3209

District address 212 House Office Bldg.
Annapolis 21401-1991
ext. 3209

Member since 1983

Athey, Tyras S. (*Dist. 32*)

Session address 100 House Office Bldg.
Annapolis 21401-1991
ext. 3469

District address 100 House Office Bldg.
Annapolis 21401-1991
ext. 3469

Member since 1967

Avara, R. Charles (*Dist. 47*)

Session address 429 House Office Bldg.
Annapolis 21401-1991
ext. 3547

District address 3508 Coolidge Ave.
Baltimore 21229-5110
410-644-3057

Member since 1967

Bartenfelder, Joseph (*Dist. 8*)

Session address 307 House Office Bldg.
Annapolis 21401-1991
ext. 3365

District address 8336 Belair Rd.
Baltimore 21236-3421
410-529-2144

Member since 1983

Barve, Kumar P. (*Dist. 17*)

Session address 224 House Office Bldg.
Annapolis 21401-1991
ext. 3046

District address 11 Pontiac Way
Gaithersburg 20878-2743
301-869-1488

Member since 1991

Bell, J. Ernest II (*Dist. 29B*)

Session address 217 House Office Bldg.
Annapolis 21401-1991
ext. 3314

District address 10 Court House Dr.
P.O. Box 362
Leonardtown 20650-0362
301-475-8421

Member since 1983

Benson, Joanne C. (*Dist. 24*)

Session address 204 House Office Bldg.
Annapolis 21401-1991
ext. 3065

District address 1891 Brightseat Rd.
Landover 20785
301-772-2802

Member since 1991

Billings, Leon G. (*Dist. 18*)

Session address 225 House Office Bldg.
Annapolis 21401-1991
ext. 3037

District address 3940 Rickover Rd.
Silver Spring 20902-2329
301-946-5916

Member since 1991

Bishop, John J. (*Dist. 9*)

Session address 308 House Office Bldg.
Annapolis 21401-1991
ext. 3359

District address 7905 Oakdale Ave.
Baltimore 21234-5501
410-661-5408

Member since 1987

Bissett, Phillip D. (*Dist. 30*)

Session address 212 House Office Bldg.
Annapolis 21401-1991
ext. 3211

District address 212 House Office Bldg.
Annapolis 21401-1991
ext. 3211

Member since 1991

Blumenthal, Rosa Lee (*Dist. 26*)

Session address 205 House Office Bldg.
Annapolis 21401-1991
ext. 3012

District address 4400 Stamp Rd., Ste. 212
Temple Hills 20748-6728
301-423-4130

Member since 1987

Bonsack, RoseMary Hatem (*Dist. 34*)

Session address 326 House Office Bldg.
Annapolis 21401-1991
ext. 3289

District address 118 West Bel Air Ave.
Aberdeen 21001-3238
410-575-6438

Member since 1991

Boston, Frank D., Jr. (*Dist. 41*)

Session address 314 House Office Bldg.
Annapolis 21401-1991
ext. 3283

District address 2200 Garrison Blvd.
Baltimore 21216-2631
410-566-3373

Member since 1987

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**Maryland General Assembly, 1993 —
Members of the House, alphabetically with addresses**

Bozman, K. Bennett (*Dist. 38*)
Session 413 House Office Bldg.
address Annapolis 21401-1991
ext. 3431

District 103 Cedar Ave.
address Berlin 21811
410-641-2221

Member
since 1991

Braun, Stephen J. (*Dist. 28A*)
Session 216 House Office Bldg.
address Annapolis 21401-1991
ext. 3247

District Waldorf Commercial Center
address P.O. Box 2037
Waldorf 20604-2037
301-932-5812

Member
since 1991

Brewster, Gerry L. (*Dist. 9*)
Session 308 House Office Bldg.
address Annapolis 21401-1991
ext. 3359

District 527 Allegheny Ave.
address Towson 21204-4233
410-821-1991

Member
since 1991

Busch, Michael E. (*Dist. 30*)
Session 212 House Office Bldg.
address Annapolis 21401-1991
ext. 3211

District 212 House Office Bldg.
address Annapolis 21401-1991
ext. 3211

Member
since 1987

Cadden, Joan (*Dist. 31*)
Session 213 House Office Bldg.
address Annapolis 21401-1991
ext. 3217

District 111 Cedar Hill Rd.
address Brooklyn Park
Baltimore 21225-3903
410-789-1914

Member
since 1991

Callas, Peter G. (*Dist. 2B*)
Session 423 House Office Bldg.
address Annapolis 21401-1991
ext. 3450

District 35 Day View Dr.
address Hagerstown 21740-6712
301-739-0212

Member
since 1983

Campbell, James W. (*Dist. 42*)
Session 320 House Office Bldg.
address Annapolis 21401-1991
ext. 3297

District 1329 1/2 W. 41st St.
address Baltimore 21211-1550
410-366-8160

Member
since 1979

Chasnoff, Joel (*Dist. 14A*)
Session 121 House Office Bldg.
address Annapolis 21401-1991
ext. 3052

District Ste. 210, Olney Bldg.
address 17904 Georgia Ave.
P.O. Box 1000
Olney 20830-1000
301-924-4200

Member
since 1975

Conroy, Mary A. (*Dist. 23*)
Session 208 House Office Bldg.
address Annapolis 21401-1991
ext. 3098

District 208 House Office Bldg.
address Annapolis 21401-1991
ext. 3098

Member
since 1986 (Senate 1982-1983)

Conway, Norman H. (*Dist. 38*)
Session 416 House Office Bldg.
address Annapolis 21401-1991
ext. 3425

District 1312 Whittier Dr.
address Salisbury 21801-3241
410-543-9060

Member
since 1987

Counihan, Gene W. (*Dist. 15*)
Session 100 House Office Bldg.
address Annapolis 21401-1991
ext. 3521

District 9901 Dellcastle Road
address Montgomery Village
20879-1322

Member
since 301-977-5045
1983

Craig, David R. (*Dist. 34*)
Session 326 House Office Bldg.
address Annapolis 21401-1991
ext. 3289

District 368 Congress Ave.
address Havre de Grace 21078-3029
410-939-9398

Member
since 1991

Cummings, Elijah E. (*Dist. 39*)
Session 141 House Office Bldg.
address Annapolis 21401-1991
ext. 3507

District 2225 St. Paul St.
address Baltimore 21218-5869
410-366-7212

Member
since 1983

Curran, Gerald J. (*Dist. 43*)
Session 321 House Office Bldg.
address Annapolis 21401-1991
ext. 3308

District Cromwell Center, Ste. 201
address 810 Gleneagles Ct.
Towson 21286-2203
410-821-2920

Member
since 1967

Currie, Ulysses (*Dist. 25*)
Session 203 House Office Bldg.
address Annapolis 21401-1991
ext. 3076

District 6621 Lacona St.
address District Heights 20747-2840
301-967-6602

Member
since 1987

Davis, Clarence (*Dist. 45*)
Session 323 House Office Bldg.
address Annapolis 21401-1991
ext. 3325

District P.O. Box 33167
address Baltimore 21218
410-366-0483

Member
since 1983

Dembrow, Dana Lee (*Dist. 20*)
Session 226 House Office Bldg.
address Annapolis 21401-1991
ext. 3200

District 2917 Schubert Dr.
address Silver Spring 20904
301-593-5359

Member
since 1987

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**Maryland General Assembly, 1993 —
Members of the House, alphabetically with addresses**

DePazzo, Louis L. (Dist. 7)
Session address 305 House Office Bldg.
 Annapolis 21401-1991
 ext. 3334
District address 38 S. Dundalk Ave.
 Dundalk 21222-4266
 410-288-9303
Member since 1979

Dewberry, Thomas E. (Dist. 12)
Session address 304 House Office Bldg.
 Annapolis 21401-1991
 ext. 3378
District address 1917 Tadcaster Rd.
 Catonsville 21228-5555
 410-747-0407
Member since 1989

DiPietro, Anthony M., Jr. (Dist. 46)
Session address 316 House Office Bldg.
 Annapolis 21401-1991
 ext. 3303
District address 225 S. Clinton St.
 Baltimore 21224-2343
 410-325-5400
Member since 1979

Dixon, Richard N. (Dist. 5A)
Session address 306 House Office Bldg.
 Annapolis 21401-1991
 ext. 3371
District address 1224 Western Chapel Rd.
 New Windsor 21776-8816
 410-848-6945
Member since 1983

Donoghue, John P. (Dist. 2C)
Session address 422 House Office Bldg.
 Annapolis 21401-1991
 ext. 3447
District address 49 Summit Ave.
 Hagerstown 21740-5522
 301-790-3780
Member since 1991

Doory, Ann Marie (Dist. 43)
Session address 321 House Office Bldg.
 Annapolis 21401-1991
 ext. 3308
District address 112 Taplow Rd.
 Baltimore 21212-3312
 410-323-0401
Member since 1987

Douglass, John W. (Dist. 45)
Session address 323 House Office Bldg.
 Annapolis 21401-1991
 ext. 3325
District address 1535 E. North Ave.
 Baltimore 21213-1480
 410-752-6653
Member since 1971

Dypski, Cornell N. (Dist. 46)
Session address 316 House Office Bldg.
 Annapolis 21401-1991
 ext. 3303
District address 638 South Decker Ave.
 Baltimore 21224-3911
 410-276-1974
Member since 1987 (Senate 1975-1983)

Edwards, George C. (Dist. 1A)
Session address 411 House Office Bldg.
 Annapolis 21401-1991
 ext. 3435
District address 23 N. Pennsylvania Ave.
 P.O. Box 8
 Grantsville 21536-0008
 301-895-5720
Member since 1983

Ehrlich, Robert L., Jr. (Dist. 10)
Session address 309 House Office Bldg.
 Annapolis 21401-1991
 ext. 3350
District address 5 Elphin Ct., #102
 Timonium 21093
 410-252-4180
Member since 1987

Elliott, Donald B. (Dist. 4B)
Session address 306 House Office Bldg.
 Annapolis 21401-1991
 ext. 3371
District address 204 Lambert Ave.
 Box 370
 New Windsor 21776-0370
 410-848-5373
Member since 1987

Exum, Nathaniel (Dist. 24)
Session address 204 House Office Bldg.
 Annapolis 21401-1991
 ext. 3065
District address 1891 Brightseat Rd.
 Landover 20785-4256
 301-772-2801
Member since 1975

Flanagan, Robert L. (Dist. 14B)
Session address 226 House Office Bldg.
 Annapolis 21401-1991
 ext. 3200
District address 12400 Clarksville Pike
 Clarksville 21029-1225
 410-988-9818
Member since 1987

Forehand, Jennie M. (Dist. 17)
Session address 223 House Office Bldg.
 Annapolis 21401-1991
 ext. 3028
District address 712 Smallwood Rd.
 Rockville 20850-2144
 301-762-4772
Member since 1978

Franchot, Peter (Dist. 20)
Session address 220 House Office Bldg.
 Annapolis 21401-1991
 ext. 3045
District address 7030 Carroll Ave.
 Takoma Park 20912
 301-270-8417
Member since 1987

Franks, C. Ronald (Dist. 36)
Session address 405 House Office Bldg.
 Annapolis 21401-1991
 ext. 3410
District address 313 Winchester Creek Rd.
 Grasonville 21638-9741
 410-758-3794
Member since 1991

Frosh, Brian E. (Dist. 16)
Session address 220 House Office Bldg.
 Annapolis 21401-1991
 ext. 3001
District address Ste. 800 West
 7315 Wisconsin Ave.
 Bethesda 20814-3202
 301-652-2888
Member since 1987

Fry, Donald C. (Dist. 35A)
Session address 326 House Office Bldg.
 Annapolis 21401-1991
 ext. 3289
District address 1714 West Jarrettsville Rd.
 Jarrettsville 21084-1524
 410-836-6747
Member since 1991

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**Maryland General Assembly, 1993 —
Members of the House, alphabetically with addresses**

Fulton, Tony E. (*Dist. 40*)
Session address 317 House Office Bldg.
 Annapolis 21401-1991
 ext. 3277
District address 3501 Dennlyn Rd.
 Baltimore 21215-7416
 410-578-1817
Member since 1987

Gallazzo, Connie C. (*Dist. 7*)
Session address 305 House Office Bldg.
 Annapolis 21401-1991
 ext. 3334
District address 305 House Office Bldg.
 Annapolis 21401-1991
 ext. 3334
Member since 1991

Gary, John G. (*Dist. 33*)
Session address 215 House Office Bldg.
 Annapolis 21401-1991
 ext. 3223
District address 215 House Office Bldg.
 Annapolis 21401-1991
 ext. 3223
Member since 1983

Genn, Gilbert J. (*Dist. 16*)
Session address 224 House Office Bldg.
 Annapolis 21401-1991
 ext. 3011
District address 1 Central Plaza, Ste. 1008
 11300 Rockville Pike
 Rockville 20852-3035
 301-881-7700
Member since 1987

Gordon, Michael R. (*Dist. 17*)
Session address 223 House Office Bldg.
 Annapolis 21401-1991
 ext. 3028
District address Ste. 330
 416 Hungerford Dr.
 Rockville 20850-4127
 301-294-2100
Member since 1983

Guns, Ronald A. (*Dist. 36*)
Session address 161 House Office Bldg.
 Annapolis 21401-1991
 ext. 3534
District address 107 Railroad Ave.
 Elkton 21921-5535
 410-392-4422
Member since 1983

Harkins, James M. (*Dist. 35A*)
Session address 326 House Office Bldg.
 Annapolis 21401-1991
 ext. 3289
District address 4 E. Jarrettsville Rd.
 P.O. Box 149
 Forest Hill 21050-0149
 410-838-6636
Member since 1991

Harrison, Hattie N. (*Dist. 45*)
Session address 323 House Office Bldg.
 Annapolis 21401-1991
 ext. 3325
District address 1054 N. Milton Ave.
 Baltimore 21205-1319
 410-342-4414
Member since 1973

Hattery, Thomas H. (*Dist. 4A*)
Session address 209 House Office Bldg.
 Annapolis 21401-1991
 ext. 3107
District address P.O. Box 88
 Mt. Airy 21771-0088
 301-694-0123
Member since 1983

Healey, Anne (*Dist. 22*)
Session address 207 House Office Bldg.
 Annapolis 21401-1991
 ext. 3058
District address 3920 Madison St.
 Hyattsville 20781-1749
 301-779-4515
Member since 1991

Heller, Henry B. (*Dist. 19*)
Session address 222 House Office Bldg.
 Annapolis 21401-1991
 ext. 3001
District address 12706 Turkey Branch Pkwy.
 Rockville 20853-3443
 301-949-4265
Member since 1987

Hergenroeder, Henry R., Jr. (*Dist. 43*)
Session address 321 House Office Bldg.
 Annapolis 21401-1991
 ext. 3308
District address 344 Homeland Southway
 Baltimore 21212-4100
 410-433-4093
Member since 1967

Hixson, Sheila Ellis (*Dist. 20*)
Session address 221 House Office Bldg.
 Annapolis 21401-1991
 ext. 3019
District address 1008 Broadmore Cir.
 Silver Spring 20904-3108
 301-384-4739
Member since 1976

Howard, Carolyn J.B. (*Dist. 24*)
Session address 204 House Office Bldg.
 Annapolis 21401-1991
 ext. 3065
District address 1891 Brightseat Rd.
 Landover 20785-4256
 301-772-2803
Member since 1991 (also 1988-1990)

Hubbard, James W. (*Dist. 23*)
Session address 208 House Office Bldg.
 Annapolis 21401-1991
 ext. 3098
District address 13305 Gallery Ct.
 Bowie 20720-3866
 301-262-7426
Member since 1992

Huff, W. Ray (*Dist. 31*)
Session address 213 House Office Bldg.
 Annapolis 21401-1991
 ext. 3217
District address 8349 Ritchie Hwy.
 Pasadena 21122-3997
 410-647-1111
Member since 1987

Hurson, John Adams (*Dist. 18*)
Session address 224 House Office Bldg.
 Annapolis 21401-1991
 ext. 3046
District address 14 Kentbury Way
 Bethesda 20814-4620
 301-654-3513
Member since 1991

Hutchinson, Leslie E. (*Dist. 6*)
Session address 303 House Office Bldg.
 Annapolis 21401-1991
 ext. 3384
District address 435 Eastern Blvd.
 Baltimore 21221
 410-780-3636
Member since 1991

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**Maryland General Assembly, 1993 —
Members of the House, alphabetically with addresses**

Jefferies, John D. (Dist. 39)

Session address 315 House Office Bldg.
Annapolis 21401-1991
ext. 3263

District address 501C Pennsylvania Ave.
Baltimore 21201-1949
410-383-2701

Member since 1988

Johnson, Samuel Q., III (Dist. 37)

Session address 415 House Office Bldg.
Annapolis 21401-1991
ext. 3427

District address P.O. Box 200
Hebron 21830
410-873-3122

Member since 1983

Jones, Christine M. (Dist. 26)

Session address 205 House Office Bldg.
Annapolis 21401-1991
ext. 3012

District address 4518 Beach Rd.
Temple Hills 20748-6788
301-423-6668

Member since 1982

Kach, A. Wade (Dist. 10)

Session address 309 House Office Bldg.
Annapolis 21401-1991
ext. 3350

District address 214 Ashland Rd.
Cockeysville 21030-1902
410-527-1962

Member since 1975

Kelley, Delores G. (Dist. 42)

Session address 320 House Office Bldg.
Annapolis 21401-1991
ext. 3297

District address Ste. 301
6615 Reisterstown Rd.
Baltimore 21215-2603
410-764-3614

Member since 1991

Kelly, Kevin (Dist. 1B)

Session address 319 House Office Bldg.
Annapolis 21401-1991
ext. 3454

District address 201 Washington St.
Cumberland 21502-2826
301-777-9000

Member since 1987

Kirk, Ruth M. (Dist. 39)

Session address 315 House Office Bldg.
Annapolis 21401-1991
ext. 3263

District address 501C Pennsylvania Ave.
Baltimore 21201-1949
410-383-2701

Member since 1983

Kittleman, Robert H. (Dist. 14B)

Session address 312 House Office Bldg.
Annapolis 21401-1991
ext. 3401

District address 12400 Clarksville Pike
Clarksville 21029-1225
410-988-9818

Member since 1983

Klima, Martha S. (Dist. 9)

Session address 308 House Office Bldg.
Annapolis 21401-1991
ext. 3359

District address 1403 Newport Pl.
Lutherville 21093-5920
410-337-2799

Member since 1983

Kolodziejski, Charles W. (Dist. 31)

Session address 213 House Office Bldg.
Annapolis 21401-1991
ext. 3217

District address 168 Carvel Beach Rd.
Baltimore 21226-1947
410-255-2043

Member since 1983

Kopp, Nancy K. (Dist. 16)

Session address 313 House Office Bldg.
Annapolis 21401-1991
ext. 3391

District address 313 House Office Bldg.
Annapolis 21401-1991
ext. 3391

Member since 1975

Krysiak, Carolyn J. (Dist. 46)

Session address 316 House Office Bldg.
Annapolis 21401-1991
ext. 3303

District address 364 Cornwall St.
Baltimore 21224-2710
410-633-2927

Member since 1991

LaMotte, Lawrence A. (Dist. 5B)

Session address 209 House Office Bldg.
Annapolis 21401-1991
ext. 3109

District address 5 Pleasant Ridge Dr.
#112
Owings Mills 21117-2554
410-581-7056

Member since 1983

La Vay, Richard (Dist. 15)

Session address 220 House Office Bldg.
Annapolis 21401-1991
ext. 3090

District address 220 House Office Bldg.
Annapolis 21401-1991
ext. 3090

Member since 1991

Levin, Theodore (Dist. 11)

Session address 310 House Office Bldg.
Annapolis 21401-1991
ext. 3342

District address 114 Slade Ave.
Baltimore 21208-4998
410-486-0462

Member since 1975

Littrell, George H., Jr. (Dist. 4A)

Session address 209 House Office Bldg.
Annapolis 21401-1991
ext. 3107

District address 5209 Reel's Mill Rd.
Frederick 21701-7320
301-662-4367

Member since 1983

Madden, Martin G. (Dist. 13B)

Session address 219 House Office Bldg.
Annapolis 21401-1991
ext. 3205

District address 11524 Crows Nest Rd.
Clarksville 21029-1602
301-596-9788

Member since 1991

Maddox, E. Farrell (Dist. 6)

Session address 305 House Office Bldg.
Annapolis 21401-1991
ext. 3332

District address 418 Eastern Blvd.
Baltimore 21221-6786
410-391-7800

Member since 1986

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**Maryland General Assembly, 1993 —
Members of the House, alphabetically with addresses**

Maloney, Timothy F. (*Dist. 21*)
Session address 424 House Office Bldg.
 Annapolis 21401-1991
 ext. 3315
District address 424 House Office Bldg.
 Annapolis 21401-1991
 ext. 3315
Member since 1979

Marriott, Salima Siler (*Dist. 40*)
Session address 317 House Office Bldg.
 Annapolis 21401-1991
 ext. 3277
District address 4515 Homer Ave.
 Baltimore 21215-6302
 410-664-1228
Member since 1991

Masters, Kenneth H. (*Dist. 12*)
Session address 304 House Office Bldg.
 Annapolis 21401-1991
 ext. 3378
District address 304 House Office Bldg.
 Annapolis 21401-1991
 ext. 3378
Member since 1979

Matthews, Richard C. (*Dist. 5A*)
Session address 306 House Office Bldg.
 Annapolis 21401-1991
 ext. 3371
District address 1309 Taylor St.
 Hampstead 21074-2217
 410-239-7600
Member since 1967

McClellan, James E. (*Dist. 3B*)
Session address 324 House Office Bldg.
 Annapolis 21401-1991
 ext. 3240
District address 215 Rockwell Ter.
 Frederick 21701-4925
 301-662-3804
Member since 1979

McClenahan, Charles A. (*Dist. 38*)
Session address 412 House Office Bldg.
 Annapolis 21401-1991
 ext. 3433
District address 4988 Annemessex Rd.
 Crisfield 21817-2526
 410-968-1444
Member since 1992

McHale, Brian K. (*Dist. 47*)
Session address 322 House Office Bldg.
 Annapolis 21401-1991
 ext. 3319
District address 801 Light St., 2nd fl.
 Baltimore 21230-3912
 410-244-8400
Member since 1990

McIntosh, Maggie Lee Ann (*Dist. 44*).
Session address 301 House Office Bldg.
 Annapolis 21401-1991
 ext. 3257
District address 3957 Cloverhill Rd.
 Baltimore 21218-1708
Member since 1992

Menes, Pauline H. (*Dist. 21*)
Session address 210 House Office Bldg.
 Annapolis 21401-1991
 ext. 3114
District address 3517 Marlborough Way
 College Park 20740-3925
 301-935-6270
Member since 1967

Mitchell, R. Clayton, Jr. (*Dist. 36*)
Session address 101 State House
 Annapolis 21401-1991
 ext. 3800
District address 101 State House
 Annapolis 21401-1991
 ext. 3800
Member since 1971

Montague, Kenneth C., Jr. (*Dist. 44*)
Session address 301 House Office Bldg.
 Annapolis 21401-1991
 ext. 3257
District address Northwood Shopping Ctr.
 1532 Havenwood Rd.
 Baltimore 21218-1694
 410-243-3904
Member since 1987

Morgan, John S. (*Dist. 13B*)
Session address 219 House Office Bldg.
 Annapolis 21401-1991
 ext. 3205
District address Ste. 210 B
 8610 Washington Blvd.
 Jessup 20794-9499
 301-776-0806
Member since 1991

Morsberger, Louis P. (*Dist. 12*)
Session address 304 House Office Bldg.
 Annapolis 21401-1991
 ext. 3378
District address 612 Hilton Ave.
 Catonsville 21228-5818
 410-747-0407
Member since 1975

Murphy, Margaret H. (*Dist. 41*)
Session address 314 House Office Bldg.
 Annapolis 21401-1991
 ext. 3283
District address 4811 Liberty Hgts. Ave.
 Baltimore 21207-7193
 410-367-5811
Member since 1978

Murray, Ethel Ann (*Dist. 35B*)
Session address 403 House Office Bldg.
 Annapolis 21401-1991
 ext. 3444
District address 553 Jackson Hall School Rd.
 Elkton 21921-2941
 410-398-2040
Member since 1983

Owings, George W., III (*Dist. 29A*)
Session address 217 House Office Bldg.
 Annapolis 21401-1991
 ext. 3231
District address P.O. Box 1177
 8217 Bayside Rd.
 Chesapeake Beach 20732
 301-855-4100
Member since 1988

Palumbo, Richard A. (*Dist. 22*)
Session address 207 House Office Bldg.
 Annapolis 21401-1991
 ext. 3058
District address 4004 St. Barnabas Rd.
 Suitland 20746-3202
 301-423-8300
Member since 1990 (also 1979-1982, 86)
 (Senate 1982-1983)

Parham, Samuel M. (*Dist. 41*)
Session address 314 House Office Bldg.
 Annapolis 21401-1991
 ext. 3283
District address 4811 Liberty Hgts. Ave.
 Baltimore 21207-7193
 410-367-7455
Member since 1989

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**Maryland General Assembly, 1993 —
Members of the House, alphabetically with addresses**

Perry, Marsha G. (Dist. 33)

Session address 214 House Office Bldg.
Annapolis 21401-1991
ext. 3223

District address 1605 Edgerton Pl.
Crofton 21114-1504
410-721-7034

Member since 1987

Petzold, Carol S. (Dist. 19)

Session address 225 House Office Bldg.
Annapolis 21401-1991
ext. 3037

District address 14113 Chadwick Ln.
Rockville 20853-2103
301-871-7413

Member since 1987

Pinsky, Paul G. (Dist. 22)

Session address 207 House Office Bldg.
Annapolis 21401-1991
ext. 3058

District address 6205 Inwood St.
Cheverly 20785
301-772-1287

Member since 1987

Pitkin, Joan B. (Dist. 23)

Session address 208 House Office Bldg.
Annapolis 21401-1991
ext. 3098

District address 12005 Long Ridge Ln.
Bowie 20715
301-262-0538

Member since 1979

Poole, D. Bruce (Dist. 34)

Session address 426 House Office Bldg.
Annapolis 21401-1991
ext. 3464

District address 9743 Beaver Creek
Church Rd.
Hagerstown 21742

Member since 301-739-6409
1987

Ports, James F. (Dist. 8)

Session address 307 House Office Bldg.
Annapolis 21401-1991
ext. 3365

District address 4546 Fitch Ave.
Baltimore 21236-3912
410-665-5871

Member since 1991

Preis, Mary Louise (Dist. 34)

Session address 326 House Office Bldg.
Annapolis 21401-1991
ext. 3289

District address 9 W. Courtland St.
Bel Air 21014-3701
410-838-5890

Member since 1991

Proctor, James E., Jr. (Dist. 27)

Session address 206 House Office Bldg.
Annapolis 21401-1991
ext. 3083

District address 11204 Cedarville Rd.
Brandywine 20613-7960
301-888-9353

Member since 1990

Rawlings, Howard P. (Dist. 40)

Session address 131 House Office Bldg.
Annapolis 21401-1991
ext. 3407

District address 3502 Sequoia Ave.
Baltimore 21215-7211
410-466-4224

Member since 1979

Redmer, Alfred W., Jr. (Dist. 8)

Session address 307 House Office Bldg.
Annapolis 21401-1991
ext. 3365

District address 4101 Kahlston Rd.
Baltimore 21236-1026
410-529-8888

Member since 1991

Roesser, Jean W. (Dist. 15)

Session address 225 House Office Bldg.
Annapolis 21401-1991
ext. 3037

District address 10830 Fox Hunt Ln.
Potomac 20854-1553
301-299-9046

Member since 1987

Rosapepe, James C. (Dist. 21)

Session address 210 House Office Bldg.
Annapolis 21401-1991
ext. 3114

District address 210 House Office Bldg.
Annapolis 21401-1991
ext. 3114

Member since 1987

Rosenberg, Samuel I. (Dist. 42)

Session address 320 House Office Bldg.
Annapolis 21401-1991
ext. 3297

District address 6615 Reisterstown Rd.
Ste. 301
Baltimore 21215-2603

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From the editor's desk:

BCBSM controversy sparks Med Chi resolution

The editor's interview with Frank Gunther, Jr., the recently appointed chairperson of the Board of Directors of Blue Cross and Blue Shield of Maryland (BCBSM), was published in the November *MMJ*. Also included were the findings of the US Senate Subcommittee on Permanent Investigations, along with the actions taken by the BCBSM board, as of press time, in response to the allegations.

Since publication of the November issue, a number of steps have been taken by the BCBSM administration and board of directors to improve the corporation's condition.

In response to the allegation of questionable management decisions, including risky or unprofitable subsidiaries

- BCBSM announced on November 16 that it will fold 11 inactive subsidiary companies by December 1, 1992 and close its arbitrage firm in a few months.¹
- During an interview Saturday, December 5, board members Gunther and Beasman indicated that BCBSM directors are forming three board committees to intensify oversight of company operations, including reviewing finances monthly, enhancing public communications, and improving service to the public and providers.²

In response to the allegations of questionable financial practices, including overstating net worth, misrepresenting BCBSM's true financial condition, and blocking government audits

- BCBSM acknowledged that \$88.1 million of the \$102.5 million it had listed in reserves for emergencies was there by special permission from state regulators, rather than because it conformed to standard accounting rules. Anticipating new rules, BCBSM reduced the value of two of its health maintenance organizations (HMOs) by \$10 million.¹

In response to allegations of excessive executive pay, including 40 individuals with salaries over \$100,000, 10 executives receiving a 181% increase in compensation in a five-year period, nearly \$18,000 per year to board members, and a 284% increase in compensation to President Sardegna over five years

- Carl J. Sardegna, BCBSM president, dismissed three top executives on November 19 and asked one other to accept reassignment. With the retirement next year of Fred Gloth, Jr., BCBSM's senior lawyer, four of the six top-paid BCBSM officers will be gone by spring.³
- Mr. Sardegna, president of BCBSM for almost seven

years, announced his resignation on December 4, 1992. The resignation was immediately accepted by the board of directors, which had been engaged in three days of meetings, discussions, and debates over the future of BCBSM. Chairperson Gunther, who has been meeting with BCBSM employees almost nonstop over the company's future and the problems it faces, said, "now we have the opportunity to come up with somebody with better skills to do the job."⁴

- William A. Beasman, Jr., retired chairperson of the Board of Directors of the Bank of Baltimore, was appointed chief executive officer on an interim basis to replace Mr. Sardegna. He resigned from the BCBSM board to take over the company's day-to-day operations.⁴
- On December 5, it was announced that the board of directors had cut its members' salaries in half and reduced their monthly meeting fees from \$800 to \$400.²
- The board announced it was "shocked" at the amount spent on outside consultants.⁷
- The board also announced that they were cancelling bonuses for top officials and were reviewing the six-figure salaries of corporate officers.⁷

In addition to these actions by BCBSM, there have been a number of new developments.

- On November 14, the *Baltimore Sun* reported that BCBSM saw its cash on hand drop in half to a new five-year low, representing about 15 days worth of claims and expenses. Company officials said one reason for the cash decrease was that BCBSM had to increase the advance payments made to hospitals by millions of dollars in order to continue to qualify for hospital charge discounts. BCBSM also had to repay nearly \$8 million when a bank canceled a subsidiary's \$10 million line of credit.⁶
- On November 16, BCBSM reported a \$11.3 million profit for the quarter ending September 30, 1992, a 28% increase over the same period last year.¹
- On Monday, November 16, BCBSM reported that so far this year, its health care management companies experienced a 6% decline in enrollment and a 13% decline in revenues. A 46% increase in earnings is necessary to meet 1992 expectations.³
- The *Sun* reported on November 20 that the board of directors is expected to announce its assessment of the company's management at the board's December meeting.³

- Governor William Donald Schaefer announced during his weekly radio talk show that he plans to hire an independent counsel, who would be paid with state funds, to "look into some of the [Blues'] problems" and "alleviate some of the misinformation we're getting."⁷
- As quoted in the *Sun* December 7th, Chairperson Gunther and Interim Chief Executive Officer Beasman vowed to move aggressively to overcome BCBSM's financial problems and a negative public image that they worry could do even more damage to the state's largest provider of health insurance.²
- Mr. Gunther announced that BCBSM would be left with \$19 million in reserves this year, assuming state regulators require BCBSM to value its assets more conservatively. While below the level recommended by industry standards, the reserve is expected to grow.²

In response to the difficulties being faced by BCBSM, Med Chi's Committee on Hospital Medical Staffs, under the chairpersonship of Ralph E. Longway, M.D., proposed the following resolution, which was approved by Council at its meeting of November 19, 1992. The resolution has been submitted to the AMA Hospital Medical Staff Section and referred to Med Chi's Legislative Committee for consideration of drafting appropriate legislation.

Whereas nonprofit entities that provide health care or support patient care should be patient advocates; and

Whereas these nonprofit entities enjoy a special tax exemption because of their nonprofit status; and

Whereas some nonprofit entities have funneled health care and/or money into for-profit ventures; and

Whereas nonprofit entities have used the money from their for-profit subsidiaries to formulate golden parachutes for executives; and

Whereas nonprofit entities have used the money from their for-profit subsidiaries to increase salaries and benefits to top executives; and

Whereas many of these for-profit ventures escape regulatory scrutiny; and

Whereas money from these for-profit ventures should be funneled back into the nonprofit entities for patient care needs; and

Whereas there are state regulatory bodies that can provide guidance with regard to nonprofit entities investing in for-profit ventures; therefore be it

RESOLVED, That if money is going to a health care entity that is providing patient care or supporting patient care that is a nonprofit entity, then the money should stay for patient care and/or support and not be placed in for-profit ventures unless the nonprofit entity obtains permission from a state regulatory body.

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Imaging Case of the Month

A 32-year-old female (gravida 3, para 1, ectopic 1) presented with severe, intermittent, diffuse abdominal pain of three-weeks duration. She had one uncomplicated pregnancy with a normal delivery four years previously, and a resection of a right-sided cornual ectopic pregnancy two years earlier. At the time of presentation, the fetus was at 30-weeks gestation, based on an initial ultrasound performed at 12-weeks gestation, which revealed a single, live, intrauterine pregnancy. An ultrasound and a magnetic resonance imaging (MRI) scan were performed.



Figure 1.

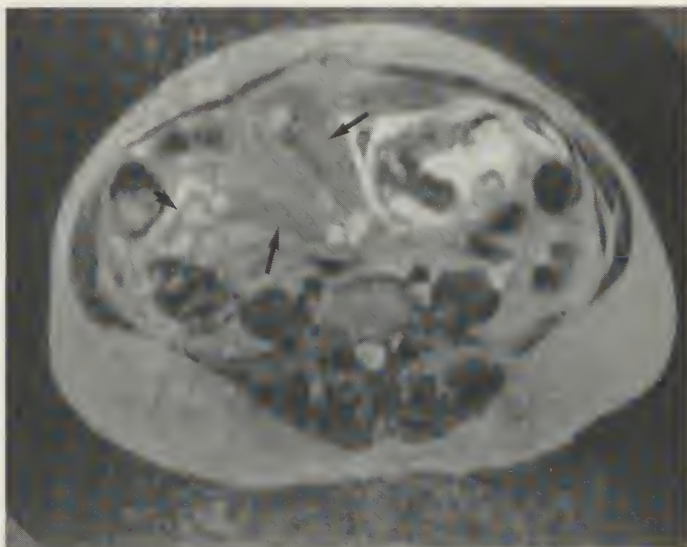


Figure 2.

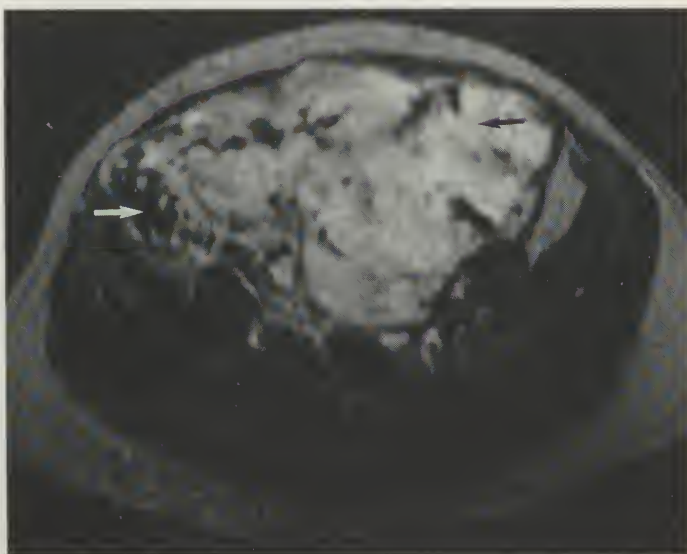


Figure 3.

Abdominal pregnancy

Figure 1. Proton density sagittal image (TR 2200, TE 20) of the maternal left side reveals the fetal head (arrow) just beneath the maternal spleen and above the descending colon.

Figure 2. Axial scan (TR 2200, TE 80, T2 weighted) shows a sagittal image of a fetal lower extremity (long arrows) with the foot (short arrow) adjacent to the maternal ascending colon. The higher signal heterogenous mass to the left of the fetal thigh is placental tissue.

Figure 3. Axial T2 weighted image of the lower pelvis reveals distorted uterine tissue on the right (white arrow) and a heterogenous mass of placental tissue on the left (black arrow). No intrauterine contents are seen. Low signal flow void (white arrow) is present in the myometrium, signifying considerable vascularity.

Abdominal pregnancy is a rare variant of ectopic pregnancy. There are 10.9 abdominal pregnancies per 100,000 births and 9.2 abdominal pregnancies per 1,000 ectopic gestations in the United States.¹ Maternal morbidity is high due to the risks of bleeding from abnormal placentation and infection.² Fetal mortality is quite high, and there is an increased risk of deformities, particularly of the face, head, and extremities, due to compression secondary to oligohydramnios.³

There are two classifications for abdominal pregnancy. In the primary form, patients usually present in the first trimester. In this setting, blastocyst implantation is peritoneal (anywhere in the abdomen) with normal fallopian tubes and ovaries, and absence of a uteroplacental fistula. The secondary form is much more common, occurs after the first trimester, and is usually related to tubal abortion or rupture with re-implantation of the fetus nearby on the peritoneum. Differentiation of the two forms is not important, as techniques of diagnosis and treatment are the same, and categorization recently has been based on gestational age or by location of implantation.⁴

The diagnosis is difficult and often delayed or missed preoperatively due to the rarity of the condition. Symptoms of presentation in early gestation are usually compatible with early tubal abortion or rupture. In advanced abdominal pregnancy, symptoms include abdominal pain, often associated with fetal movement, absent Braxton-Hicks contractions, vomiting, anemia, and fetal position high in the abdomen.^{3,5} The diagnosis should be considered in the differential diagnosis of unexplained fetal demise, or an elevated serum alpha-fetoprotein.⁶

Ultrasound has replaced plain film radiography in aiding in the diagnosis. It can show an abnormal relation of the fetus, placenta, uterus, amniotic fluid (if present), and ab-

normal fetal lie, but can be limited due to distorted pelvic anatomy and overlying bowel gas. MRI has recently been shown to be useful in depicting these abnormal relationships, often in more definitive detail.^{7,8} It is illustrative in the evaluation of fetal deformities as well as placental implantation and its relationship to pelvic organs and their vascular supply, assisting preoperative planning.⁴

Management is surgical and usually advisable at the time of diagnosis. The operative scenario includes an experienced OB/GYN surgeon and neonatologist with a vascular surgeon standing by, blood for transfusion available, and placement of military anti-shock trousers (MAST).⁴ However, in advanced cases of 20-weeks gestation or greater, with mother and fetus doing well, expectant management in the hospital is often elected until the fetus is viable.⁹

In the current case, sonographic evaluation at the time of presentation was able to document an abnormal relationship of the uterus and fetus; however, MRI added additional detail of the uterine-placental relationship. There was oligohydramnios, but fluid was in the fetal stomach and bladder. The case was managed expectantly and serial ultrasound exams showed appropriate fetal growth. At 38 weeks, the fetus was delivered. The placental mass was fused to the uterus and was hemorrhaging, requiring a hysterectomy. The anatomy was so distorted that no definite uterine rent was identified, but it is thought that this abdominal pregnancy was of the secondary type. A small portion of maternal omentum had necrosed and was resected. The fetus was not deformed. Both mother and baby are alive and well.

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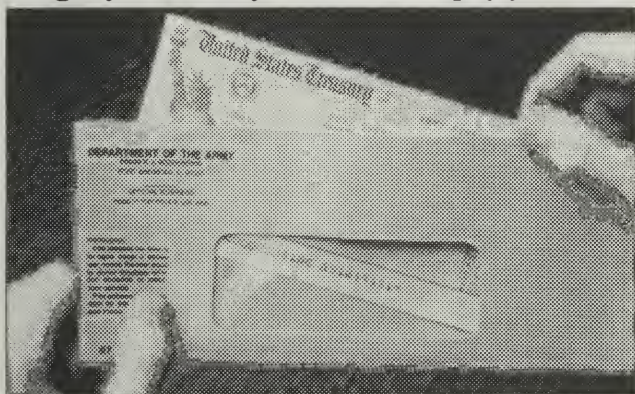
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Acoustic neuroma: Summary of the NIH consensus

An acoustic neuroma is a relatively common and potentially serious brain tumor that can cause death by compressing vital structures including the cranial nerves and the brainstem. The tumor forms within the internal auditory canal at the base of the brain and accounts for 5% to 10% of all intracranial tumors. An estimated 2,000 to 3,000 acoustic neuromas are diagnosed in the United States each year. Initial symptoms of acoustic neuroma consist of changes in hearing or hearing loss, tinnitus (ringing in the ear), and poor balance.

In order to reach agreement on defining the various types of acoustic neuroma, on which procedures are useful for screening and diagnosis, on treatment options and their complications, and on key areas for future clinical and basic research, the National Institute of Neurological Disorders and Stroke and the NIH Office of Medical Applications of Research held a Consensus Development Conference on Acoustic Neuroma (December 11–13, 1991). The National Institute on Deafness and Other Communication Disorders and the National Cancer Institute cosponsored the conference. A summary of the consensus panel's findings follows.

Acoustic neuroma can be more accurately called a vestibular schwannoma, because the tumor is composed of schwann cells—cells that form the protective sheath around the nerves of the peripheral nervous system—and typically affects the vestibular rather than the acoustic part of the 8th cranial nerve. Little is known about the control of schwann cell growth in humans and the factors that may contribute to formation of vestibular schwannomas. All cases of vestibular schwannomas are thought to result from functional loss of a tumor-suppressor gene localized to chromosome 22. In at least 95% of patients, the disease is unilat-

eral (tumors develop on only one side of the brain) and sporadic (occurs randomly in the population). About 5% of patients have bilateral vestibular schwannomas (tumors develop on both sides of the brain), a feature of an inherited disorder known as type 2 neurofibromatosis (NF2).

There is no family history of the disease in about one-half of all individuals with NF2, suggesting that these individuals have new gene mutations and may transmit the disorder to future generations. These individuals tend to be more severely affected than patients with the inherited disorder. Patients with NF2 may also have associated tumors (such as gliomas and neurofibromas), cataracts, and small marks on the skin known by their appearance as café au lait spots. In some families, meningiomas occur, but rarely, the onset of vestibular schwannomas is delayed, and the progress of the disease is quite slow. In other families, meningiomas are much more common, the onset is earlier, and the progression is more rapid. Recent studies have raised the possibility that in familial cases, the onset of symptoms may be earlier and their severity greater when the disease is inherited from the mother. The gene that causes NF2 is expected to be identified in the near future. Once this gene is identified, the differences among NF2 families and differences in the growth rate among tumors may become clear.

Progressive hearing loss in one ear is the most common symptom in sporadic cases of vestibular schwannoma and is found in 90% of these individuals. Sound may be distorted, often while patients are using the telephone. Approximately 10% of patients, however, report sudden hearing loss. Less common symptoms in patients with vestibular schwannoma include tinnitus (ringing in the ears) with or without vertigo (dizziness or disequilibrium).

When the tumor presses on neighboring structures, symptoms may also include headache, ataxia (unsteadiness), facial pain, double vision, and swallowing and speech difficulties.

Diagnosis of vestibular schwannomas should begin with a thorough physical examination. Physicians should pay special attention to hearing and balance, the eyes, the cranial nerves, and the skin. Audiological examination should consist of basic testing as well as brainstem auditory evoked responses (BAER) and testing of acoustic reflex and reflex decay. The definitive diagnostic study that can be performed, however, is magnetic resonance imaging (MRI), enhanced by the contrast medium gadolinium. MRI is capable of revealing vestibular tumors as small as a few millimeters in diameter. False positives are rare. Vestibular testing is thought to be of less diagnostic value in comparison with the audiometric tests listed above. When it is necessary to visualize the temporal bone and calcified brain lesions, computerized axial tomography (CT) is useful.

The ideal treatment for most patients with vestibular schwannoma is surgery. Other options include observation, partial removal of the tumor, and radiation, including stereotactic radiosurgery. Advances in microsurgical techniques, anesthesia, and care during the operation have significantly reduced morbidity and mortality and enable total removal of the tumor in a majority of cases. Young patients with progressive neurological symptoms or growing tumors clearly are candidates for surgery. The prognosis for preserving hearing following surgery is especially favorable for those patients with mild hearing loss and preoperative BAER recording with well-demonstrated waves. When MRI shows a tumor larger than two centimeters or when the tumor fills the internal auditory canal, surgery may result in the loss of useful hearing.

There are, however, some patients who may not be eligible for surgery or who may be at a greater risk for complications from surgery. These include

continued next page

older people and other patients who have neither severe neurological symptoms nor evidence of tumor growth. Conservative management may be appropriate for those individuals who have small, relatively asymptomatic tumors revealed by gadolinium-enhanced MRI. The physician should discuss the risk of neurologic deterioration with such patients.

The best surgical setting for the treatment of vestibular schwannoma is a medical center that has a highly organized and dedicated team with a specific interest in these tumors. Comprehensive surgical treatment requires collaboration between many disciplines. It is important that the health care team provide enough information to patients and their families, both before and following the treatment, so that they have a realistic expectation of outcome, including risks, and complications. Many complications can be less devastating and problematic if patient needs and expectations are addressed preoperatively with precise knowledge of possibilities for the future. Referral should be made to peer support groups early in the process.

Complications of treatment may be most severe in NF2 patients. There may be a risk of hearing impairment in both ears and consequent severe disability. One side may progress more rapidly. Loss of functional hearing in one ear raises issues for treatment of the tumor on the side with better hearing. Total loss of hearing occurs in many NF2 patients.

Surgical complications include air embolism, intracranial hemorrhage, stroke, cerebrospinal fluid leakage, and meningitis; these tend to occur in the first 72 hours. Loss of hearing in the operated ear is the most common adverse consequence. Intraoperative monitoring of auditory brainstem response may play an important role in improved hearing preservation. Abnormal vestibular function will occur in almost all patients, marked by dizziness and imbalance. Vestibular dysfunction becomes significant when it is bilateral or occurs in conjunction with other cen-

tral nervous system or sensory impairment. Patients with bilateral vestibular problems are at increased risk for drowning when swimming, diving, or bathing.

The most distressed complication of surgery is disfiguring facial nerve weakness or paralysis, and intraoperative monitoring of cranial nerve function is important for preservation of facial nerve function. Treatment for facial nerve damage, which can cause serious emotional, psychosocial, and possibly professional problems, includes surgery and physical and occupational therapy. None of these, however, can restore normal function and appearance. Other complications may include incomplete closure of the eye, headache, and damage to other cranial nerves.

Radiation is a treatment option limited primarily to patients unable or unwilling to undergo surgery. The best experience to date has been with stereotactic radiotherapy, a new, promising treatment option. Complications may occur later than with surgery, and there is little information available on long-term patient followup. Complications include a high rate of hearing loss within 1 year after therapy, and there may be delayed damage to 5th and 7th cranial nerve function. Other options include photo and particle beam therapies. In the majority of patients, tumor growth can be controlled.

An important component of management, regardless of the method of treatment, is patient follow-up, including a history of new findings, progression of symptoms, repeated neurologic examination, audiologic assessment, and radiographic imaging. Intervals range from every three months initially to every one to two years, depending on the patient's clinical course. The duration of patient followup ranges from five to ten years (or longer). Since tumors can recur, all cases need to be followed by imaging.

The consensus statement also recommended a number of areas for future research. Genetic mapping of the NF2 gene and MRI have opened major

continued on next page

Acoustic neuroma: A response

The changes that have occurred in the treatment and, especially, in the diagnosis of acoustic tumors, illustrate the progress made in neurosurgery and neuroradiology over the past 80 and, in particular, the past 20 years.

In 1905, Krause described a method of finger dissection to remove cerebellopontine angle tumors, with a mortality rate in excess of 67%.¹ Harvey Cushing introduced a wide, bilateral suboccipital craniectomy approach to these tumors and, in his classic monograph,² reported about a 13% mortality rate for an intracapsular removal of these lesions. This did not represent cure, since about 40% of these patients succumbed to tumor recurrence. However, Cushing's contribution to the lowering of the surgical mortality rate was eclipsed by Walter Dandy's report of 1917, in which Dandy described the total surgical extirpation of acoustic tumors by means of a unilateral suboccipital approach, internal decompression of the tumor mass, and, finally, complete removal of the tumor capsule from the adjacent brainstem and surrounding structures.³ By 1941, Dandy had operated on 46 such cases with a mortality rate of 11%.⁴ All patients lost their hearing on the side of the tumor, and nearly all suffered ipsilateral facial paralysis.

Today, the surgical approach to the extracranial acoustic tumor remains, in many ways, similar to that of Dandy's. The principle of intracapsular removal of a tumor followed by careful dissection of the capsule and its total removal is the same, except for the addition of microsurgical techniques, which greatly aid the surgeon in visualizing the structures often attached to the tumor capsule and assist the surgeon in sparing them harm.

The acoustic neuroma is a benign tumor in a malign location, and as it slowly grows, it disturbs its neighboring structures, such as cranial nerves IX, X, and XI below the jugular foramen; the facial and acoustic/vestibular nerves at the ponto-medullary junction (the facial nerve often lies on the anterior portion of the tumor capsule); the pons itself medially; the trigeminal nerve root and petrosal vein above; and the cerebellum posterolaterally. The physiological decompensation of these structures eventually gives rise to the characteristic syndrome of tumors of the cerebellopontine angle. Some degree of hearing loss and/or tinnitus are usually early symptoms of acoustic tumors, since these le-

sions arise as nerve sheath tumors (schwannomas) of the eighth cranial nerve. Cerebellopontine angle tumors, which do not give rise to hearing loss as a major symptom, are often not acoustic neuromas, but are more likely to be meningiomas or tumors of other much less common histologies. Similarly, tumors of the cerebellopontine angle, which are associated with some hearing loss, and which widen the bony aperture of the internal acoustic meatus, are nearly always acoustic neuromas.

The operating microscope has been used in acoustic tumor surgery for about thirty years, and has improved the outcomes in many patients. The surgery can now be done with very low mortality, and preservation of the facial nerve is common in operations involving tumors of less than two centimeters, and frequently in larger tumors. With small tumors, even hearing can be preserved in some cases.

As with all difficult, and sometimes incurable, illnesses, alternative approaches exist for the treatment of acoustic tumors. The NIH consensus statement mentions that "radiation is a treatment option limited primarily to patients unable or unwilling to undergo surgery. The best experience to date has been with stereotactic radiotherapy, a new and promising treatment option. Complications may occur later than with surgery, and there is little information available on long-term patient follow-up." Each of these approaches offers potential risks and side effects. These two modalities are included, neither as conventional adjuvants to surgery, nor as reasonable alternatives to surgery, but more

new areas of research. There is a need for clarification and standardization of terminology used to report results of treatment and for a national vestibular schwannoma patient registry. In addition, a cell repository and tissue bank would facilitate genetic research. Once the NF2 gene is identified, vestibular schwannoma could become a candidate for gene therapy. The cloning of the gene could ultimately lead to the development of animal models of the disease in transgenic mice.

Single free copies of the complete *NIH Consensus Statement on Acoustic Neuroma* may be ordered from the Office of Medical Applications of Research, NIH, Federal Building, Room 618, Bethesda, Maryland 20892 (301-496-1143).

for the sake of completeness in order to give the clinician a catalogue of treatments that might be considered should surgery be an impossibility. Certainly, stereotactic radiosurgery is too new a procedure to assess its efficacy and long-term complication rate in the treatment of these benign lesions of the cerebellopontine angle. Specifically, its rate of facial nerve paralysis has yet to be determined, especially as the number of stereotactic radiosurgery units increases and more patients with acoustic tumors may be treated.

The NIH consensus statement unfortunately tends to lump all types of surgery for acoustic tumors together, but this is inappropriate. Acoustic tumors of different sizes and with

different anatomic features may lend themselves to different kinds of surgical approaches. The unilateral suboccipital approach described by Dandy is ideal for large tumors, but small intracanalicular lesions may be approached by microsurgical dissection of the temporal bone. The surgical approach taken to an individual tumor has an elegance all its own, and an experienced acoustic surgeon will tailor his or her approach to the anatomic characteristics of the lesion. In so doing, the surgeon offers the patient the lowest probability of damage to the structures of the cerebellopontine angle, and the highest probability of cure.

One hopes, as approaches other than surgery are taken to the challenging treatment of acoustic tumors, that careful and honest outcome records will be kept by the centers treating these patients, so that those of us faced with these treatment decisions five and ten years from now will be well-informed.

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RONALD J. COHEN, M.D., F.A.C.S. ■

A Clinical Moment with Diabetes

Ultralente and multiple shots of regular insulin

Prescribing NPH and Regular Insulin before breakfast and dinner may initially be used in an effort to control patients with type 1 diabetes. Despite careful adherence to a dietary regime, frequent glucose checks, and other efforts on the part of the physician to adjust the insulin therapy, a patient may continue to have hyperglycemia—with a glycohemoglobin test being 8.8 percent (normal 4-6). What can be done to better control glucose levels?

There are several approaches to improving glucose levels, all of which entail using insulin in what is called a more intensive regime. One of these approaches is to use Ultralente Insulin, with multiple shots of Regular Insulin. A method that I have found to be very useful and well tolerated is to prescribe UltraLente and Regular Insulin before breakfast, a dose of Regular Insulin before lunch, and then again a dose of Ultralente with Regular Insulin before dinner. Typically, the Ultralente dose is divided in half between the morning and evening shot.

The total daily dose of the Ultralente Insulin is adjusted until the patient has the best possible control of fasting glucose levels. Then the dose of each Regular Insulin is adjusted until the patient obtains the best possible degree of postprandial control after each meal. At that point, the insulin doses generally remain relatively constant with adjustments made based on fingerstick blood sugar readings.

The dose of Ultralente Insulin is usually split, as I have found that this reduces the frequency of hypoglycemia during the middle of the night. The Regular Insulin is given before each meal so that there are no excessive after-meal glucose elevations. In my experience, in many, many cases, this more "physiologic" insulin regime works very well to control glucose levels in a good range while having a very acceptable degree of hypoglycemic episodes.

BRUCE SINDLER, M.D. is a diabetologist and endocrinologist in private practice in Pikesville, MD.

JAMES H. MERSEY, M.D., editor ■

A Clinical Moment with Diabetes

"A Clinical Moment with Diabetes" is a monthly feature of the Maryland Medical Journal. The format includes the presentation of a clinical problem or mini case study, followed by a solution or response. Physicians interested in providing submissions for publication consideration should contact the department editor: James H. Mersey, M.D., Chief, Division of Endocrinology, Physician Pavilion, 6565 North Charles St., Suite 411, Baltimore, MD 21204. 410-828-7417

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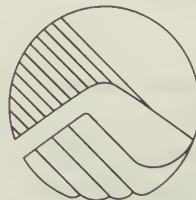
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A Look Back

A study of shock and trauma in man utilizing the resources of a clinical shock trauma unit

Reprinted from the *Maryland State Medical Journal*. 1967; 16(3): 63-65.
R. Adams Cowley, MD

Dr. Cowley was professor and head, Division of Thoracic Surgery, University of Maryland School of Medicine.

From the Clinical Shock Trauma Unit, University of Maryland School of Medicine, Baltimore, MD. Supported by the US Army Medical Research and Development Command, Department of the Army, under Research Contract No. DA-49-193-MD-2229.

Severely injured individuals are constantly present in large general hospitals, particularly those associated with medical schools such as ours. While we do our best to treat these people, many deteriorate and die. Unlike most patients, who are hospitalized for acute or chronic disease and for whom some type of definitive therapy and care is planned, the accident- or emergency-ill victim becomes on admission an unwelcome patient since the hospital family is neither prepared nor geared to handle his emergency in a desirable manner. He is most likely to be seen by the least experienced house staff physician, the intern, during a period when time is of the essence and ripe clinical judgment is essential for his survival.

Today, shock and trauma therapy is often self-defeating for a number of reasons. Good care seems less than aggressive because young physicians who staff emergency rooms are ill-prepared to make even the first decisions that may be lifesaving. Decisions are often compounded by a compromise with inadequate treatment facilities, by harassment and pressure on a busy Saturday night with the intern, alone "on call," and by the impossibility of consultation because the senior staff member is busy in the operation room or treating another emergency on another floor. Could you, under these circumstances, provide care? Probably you could, but it would only be through mature *experience and judgment*.

Do you hear in your emergency room, "Get a chest x-ray!" and find the patient died while being turned on the x-ray table because an already stressed homeostatic system was thus overtaxed? Or, "Let's continue to watch the patient, he seems all right now," and know that precious minutes are lost at a point when rapid prophylactic resuscitation could have forestalled need for long, arduous refractory shock therapy? Do you hear, "Get the pressure up, start vasopressors!" and realize that he is reenforcing the vicious cycle of vasospasm while the lifesaving tissue perfusion ebbs away? Would not the simple technique of establishing a central venous pressure have given more information?

This present dilemma of emergency care can be expected because most medical schools have done little to teach trauma beyond minimal first aid and have structured student trauma education at the house staff level. Trauma and shock, as areas of special interest, have attracted few supporters.

The hospital attitude toward this problem is one of apathy in failing to provide the ancillary support so essential for proper care of the severely ill. Chemistry and blood gas laboratories are seldom available at night and on weekends when the incidence of accidental injury is greatest. Unavailability of proper x-rays, inadequate blood bank service, and the skeletal staffing of physicians and nurses on holidays and weekends,

further handicap the *experienced* as well as the *inexperienced* physician.

These factors and many others perpetuate the same inadequate teaching, training, and therapy experience year after year. It is little wonder, then, that young physicians who are so well trained in most other aspects of medicine are poorly equipped to make proper decisions for resuscitation and emergency care. In the event of disaster or war, their inexperience in this area could have a calamitous effect.

The public attitude toward trauma is one of indifference because in the experience of the layman the physical injuries that are seen are usually sudden, mutilating, distasteful, gruesome, and indicative of unlikely survival.* As a result, to the layman *perfunctory treatment is acceptable!* Many people are thus allowed to die by general consent since the physician, the hospital, and the public have not accepted their responsibilities in trying to improve this desperate situation.

The total treatment of injured people on the basis of existing information is inadequate in most situations. Therapy continues to fall into a pattern of guess-work because the physician is unable to study the trauma patient who fails to respond to treatment. Scientific study and observation, along with good care, are synonymous with good therapy and the right of every patient. Inability to collect scientific information on what is taking place under conditions of therapy can only result in mediocre patient care. If scientific observations are not made during this period,

the experience is lost and the physician is really not accepting his responsibility to the patient for he cannot otherwise guide therapy in the direction of decreasing mortality and morbidity due to accidental injury. Would it not be better if our profession solved the problem by converting all available resources into a plan for emergency care?

Awareness at the University of Maryland School of Medicine of problems related to injury and shock has resulted in the establishment of a Clinical Shock Trauma Unit (CSTU) to study the physiological, immunobacteriological, and biochemical responses to injury in man. This unit has been in operation for the past four years. Since as far back as 1956, however, an extensive study of shock and its mechanism has been the major research interest of Dr. Robert W. Buxton and the Department of Surgery. The studies were initially limited to the animal experimental laboratory. As they progressed, two important factors became evident: (1) Although animal experimental work was necessary for many base line and model studies, variance in response of different species indicated the necessity to study shock in man more directly; and (2) in order to understand the overall structural pathophysiological, immunobacteriological, and biochemical alterations occurring in the organism, it was necessary to expand the program to include multidisciplinary support in order to explore effectively the basic phenomena occurring at the cellular level.

To date, we have studied shock in man with complementary support from animal investigation. The main features of the study are: (1) elucidation of physiologic and biochemical mechanisms of clinical shock, (2) development of therapeutic regimens,

and (3) research and development of preventive measures.

The mechanisms of operation have included (1) establishment of a Clinical Shock Trauma Unit for resuscitation, where pertinent data on trauma patients are collected on a 24-hour basis and (2) modification of the animal research program in order to provide experimental data needed for support of observation in humans. Both the CSTU and the animal research program are operating effectively and, as a result, we have a large amount of previously unobtainable clinical, physiological, and biochemical data on patients in various types and stages of shock.

Preliminary analysis of the data already shows that it is not only feasible to study a state of a patient as manifested by various measured parameters, but it is also possible to investigate dynamic changes of these parameters and their mutual interdependence. This was our primary objective in collecting the data and required an extensive data analysis program.

Since inception of the study in January 1962, over 300 patients in various stages of shock have been studied as they have undergone resuscitation measures. Some of our results have already been reported.¹⁻¹⁴ We believe we have proven that patients can be successfully studied during resuscitation; we have also demonstrated that the techniques developed and used have done much to improve therapy and to increase the survival rate. These experiences with the present CSTU now permit more complex studies of the physiobiochemical response to injury in man and constitute a solid basis for a second and even more fruitful phase of shock and trauma research. Hypotheses already formulated will now permit more

* "Newspapers do not usually publish pictures of such injuries because they are horrifying and shocking to the public—people do not like to see them."—Sterling Noel, editor, *Baltimore News American*.

A LOOK BACK

efficient and more purposeful collection of data. Further analysis of both available and new data continues to yield additional tests of the formulated hypotheses and will lead to new conjectures that will make future shock research more challenging.

Steps taken by our group are only initial steps in specific areas of this neglected disease of modern society.¹⁵ The responsibility for proper care of the emergency-ill lies with us all.

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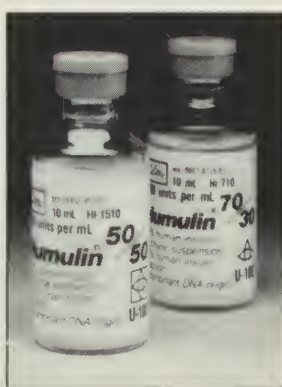
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Book Reviews

Keys to Winning Physician Support. A Guide for Executives and Managers.
R.E. Thompson. Tampa: Hillsboro Printing Company. 1991. 83 pages. \$25.95

Dr. Thompson has produced a well-written book which is a direct outgrowth of the multiple changes that have occurred in the practice of hospital medicine in the last century. His thesis is that the novel institutional problems created during this period can be more readily solved by discarding the established method of government and reaching forward through entrenched narrow-minded disciplines to embrace the concept of having a physician-executive (medical director) help guide matters, under the overall aegis of a chief executive officer. The medical director, having been trained as a physician and possessing the basic characteristics of a business executive, would more easily solve the difficulties of meeting the budget, marketing the wares of the hospital and its staff, and managing personnel issues, legal matters, and government regulations in this new era of medicine. He contends that the physician-executive was, until recently, an oxymoron, and he attempts to show that every hospital will function better by having a medical director.

In 1950, George Orwell wrote an exceptionally keen satire of modern times (1984) in which he sounded a dreadful warning of possible changes in our society. The main character, Winston Smith, was a party functionary who became mesmerized and frightened by the politics of tyranny which Orwell created. Reading Thompson's book leaves me with a fear of a medical future that parallels the illusory culture tailored by Orwell.

The author of this guide, which describes how managers and executive assistants can coerce doctors, wrote that by the year 2001, the nature of the organized medical staff

will have changed radically. The medical executive committee, as a group, will have disappeared and will be replaced by a cabinet of a few physicians. Clinical department chairpersons will be selected for medical and business skills.

The entire book is devoted to winning physician support for this new brand of administrative medicine. The executive class, data-oriented and responsible for implementing the change, looks at the practicing doctor as necessary for the conduct of the art of medicine, but unable to cope with the multiple challenges of getting improved equipment, larger buildings, and developing ways to cope more effectively with the federal government's fiscal system.

He does indicate, however, that management should be concerned about what physicians think about new projects. Viewed in terms of dollars and cents, time spent winning physician support for contemplated projects would seem productive. All businesses must experience significant growth if a profit is to be made.

Numerous changes have occurred in the administration of hospitals in America since the first one was created by Dr. Thomas Bond and Benjamin Franklin for the care of the "sick, injured, and lunatic." Chartered in 1751, the hospital opened a year later. The founders of the institution thought that it would also provide instruction for young men seeking to become doctors. As hospitals grew in size, they acquired by necessity, a nonmedical staff for the business and housekeeping parts of the enterprise. Doctors once controlled hospital activity with lay superintendents who were subservient to the medical board. Now, administration is effected by a chief

BOOK REVIEWS

executive officer and a hierarchy, as the business of running a hospital has become more complex. The entry of the federal government into the health care system has produced complicated mechanisms of repayment that need interpretation by the hospital staff.

Unquestionably, in this era of super-hospitals, some form of organizational control of the strictly business part of the relationship with patients must exist. Hospitals were created for the care of strangers in a humane manner; however, a distinct loss in human relationships would occur if the loving, devoted spirit of the doctor was removed from institutional care. Thompson sometimes only values physicians in terms of bringing multiple days of care to the hospital, and favors physicians with the biggest referral practice. Perhaps the observation is valid in this time of metered hospital medicine.

Management, in maintaining a financially stable institution, must occasionally secure approbation from staff physicians for contemplated projects of expansion, to provide the *modus operandi* for them. Apparently, the bigger and more diversified the hospital, the greater the financial returns. The entire art of medicine, however, should not be sacrificed to achieve this envisioned result. The history of the present illness should not be started with "What sort of insurance do you have?"

Thompson lists a number of errors that executives think physicians make: they refuse to recognize authority or accept organizational skills, and they believe that they alone understand medical practice. In addition, they resist change and many are arrogant. These observations will not be well received by the majority of practicing doctors.

He suggests that the effects of these undesirable personality changes may be mitigated by the work of a successful vice-president for medical affairs, who will guide and supplement the efforts of the practitioners. He will relieve them of executive duties, as he feels most doctors should not be concerned with decisions that involve matters not strictly of a medical nature. In addition, he serves as a buffer between the physicians and the legion of auxiliary services in the institution. In such a mode of existence, the doctors may readily become the drones to the executive queen bee.

Removing the medical staff from the concerns of the hospital is a major step toward complete commercialization, a plane that we are rapidly approaching. Perhaps 1984 will come soon in its entirety for physicians, but the time to forestall such a catastrophe is now.

Surely the place of the doctor in American society and in hospitals has changed markedly during the last century. At one time, the physician was a respected leader in the community and a guiding light in the hospital, but a gradual erosion has taken place. Part of this decay is due to a lack of interest in medical matters external to actual practice. A broader view must be re-established before a complete capitulation to the business hierarchy occurs. Although non-medical people must do the housekeeping chores and be interested in the financial preservation of the hospital, the physician should be re-elevated to the state described by Homer. "A healer is worth many men in his knowledge of cutting out arrows and putting kindly medicine on wounds."

JOSEPH M. MILLER, M.D.
Timonium

The Dictionary of Modern Medicine. J.C. Segen. Park Ridge: The Parthenon Publishing Group. 1992. 800 pages. \$75.00

When Pope, in a most knowledgeable fashion, wrote—"What oft was thought, but ne'er so well expressed," he unknowingly supplied a description of this extraordinary dictionary by Segen. Perhaps primarily written for a medical audience, the book will nevertheless be welcomed by a wide variety of professional groups and the laity. Knowledge gaps in fast-changing scientific terminology may be easily bridged by reference to this encyclopedic work. Tremendous advances in the numerous branches of medicine have produced an undecipherable nomenclature to many. Experts in one field will soon learn that they are frequently novices in numerous other fields.

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BOOK REVIEWS

been struggling with a word, an acronym, or a disease, give yourself a treat and read about it in a simple, concise presentation in this source book of currently used medical expressions. The libraries of secondary schools, colleges, and medical schools, as well as the public libraries, will find this volume a well-used addition to their reference collection.

The author, a certified pathologist in the New York metropolitan area with a strong interest in immunopathology, is well prepared to write this reference book.

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in *Rauwolfia Serpentina* (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage, although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral alpha-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.^{1,2} Also dizziness, headache, skin flushing reported when used orally.^{1,3}

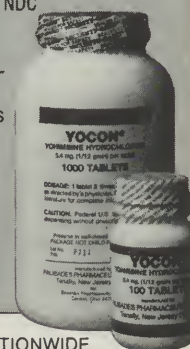
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.^{1,3,4} 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.³

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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In Memoriam

Raymond M. Atkins, M.D.

RAYMOND M. ATKINS, M.D., past president of Med Chi, died November 13 of cancer. Dr. Atkins, age 65, was a general and vascular surgeon. He was born in West Virginia and moved to Baltimore where he attended City College. He then attended several colleges under a World War II program for prospective naval officers. When the war was over, he received his undergraduate and medical degrees from the University of Maryland. He had a general practice in Chestertown before deciding to specialize in surgery. At that time, Dr. Atkins returned to Baltimore for a residency at

Church Hospital. He was chief of staff at Church Hospital from 1975 to 1981 and had also been on the staffs of the Greater Baltimore Medical Center, and Union Memorial, St. Joseph, and Good Samaritan hospitals. Dr. Atkins maintained a surgical practice in Baltimore for the last 30 years. He was also a physician in the National Guard and then in the army reserve where he retired as a decorated command surgeon with the rank of colonel.

To honor the memory of Raymond Atkins, M.D., Jose Martinez, M.D. presented the eulogy at Dr. Atkins' funeral service.

Raymond Atkins was a gentleman in every sense of the word.

Ray was a man in every sense of the word—his maleness springing from his integrity, his honesty, his dedication.

Ray was gentle in every sense of the word—his gentleness, his kindness, his compassion flowing from his heart.

Ray knew himself to be a child of the Lord and as such, he had a deep respect for himself. Respect not so much for who he was but for what he was. Respect for the graces God had bestowed on him, for the knowledge God had invested in him and for the responsibility with which God had charged him.

It is Ray's self-respect that mirrored itself in the respect he had for people and the events that became part of his life, however transiently.

Ray respected his patients, for he was one of those rare physicians who knows that his mission is to care for people not just treat their illness.

Ray respected the staff, physicians, and others alike, with whom he worked, knowing that the daily achievements of medicine are not in the flashy successes of single individuals who demand that others work and serve them, but rather in team effort where the humblest task, well done, calls forth the respect of all.

Ray was respected by his colleagues. Time and time again he was summoned by his peers to lead them not only in his own specialty of surgery, but across specialty lines as president of the hospital medical staff, and then across hospital lines as president of the Baltimore City Medical Society, then across county boundaries as president of the state medical society and beyond state boundaries when he was elected to the highest physician council in the United States, the House of Delegates of the American Medical Association.

Ray respected this nation and his citizen obligations to

his country, and when his country called, Ray joined its armed forces. And the country recognized his contributions when it granted him, among many others decorations, the Legion of Merit.

But while obligations can be satisfied, duty knows no end and Ray joined, busy as he was, the reserve, reaching the rank of full colonel.

But it was when Ray spoke of his family, of Julie and the children, that you could tell the excellence of his leadership. For you knew that there was a man who supported and succored, advised and guided, but never directed, ordered, or compelled, as he watched Julie be the supporting companion he sought and the children grow into their self-sufficient, independent legacy to society.

But one should not think of Ray as so obsessed by his tasks, so possessed by his goals, that he ignored society. Ray, in his leadership, denounced incompetence, unearthened dishonesty, unmasked venality, and exposed those lacking in the integrity so necessary to physicians. But when he did, it was always with cause and never capriciously, maliciously, or for personal gain.

Neither should one think of Ray as dour and sour, a mirthless individual. Ray had a great sense of humor, which blossomed when occasion arose. But in doing so, Ray never used humor to diminish others. He never chose, as so many do, the word that hurts, the phrase that wounds.

Ray has been called away.

Please join me in observing a few moments of silent prayer, not only to taste the bitterness of our loss but to gratefully raise our hearts to the Lord and thank him for having allowed us to know Raymond Atkins who has and will continue to enrich our lives.

For though his own time on this earth has ended, he will forever be present within us.

Nestor de Venecia, M.D.

NESTOR DE VENECIA, M.D., a family practitioner and general surgeon, died October 29 at the age of 69. A native of Dagupan City in the Philippines, Dr. de Venecia graduated from the University of the Philippines and its medical school in Manila. In 1950, he came to the United States and was a resident in anesthesiology at Duke University Hospital and then a surgical resident at University of Maryland Hospital. He was also a fellow in cardiovascular surgery at Georgetown University. In 1962, Dr. de Venecia returned to the Philippines and practiced in Dagupan City until 1968. He then returned to the United States and worked in the emergency room at Prince George's General Hospital before opening a practice in Columbia, Maryland in 1972. A member of the Howard County Medical Society, Dr. de Venecia was on the staff of Howard County General Hospital.

Jivaka B. DeSilva, M.D.

JIVAKA B. DESILVA, M.D., an orthopaedic surgeon, died November 14 of cancer. Dr. DeSilva, who was 51, was born in Colombo, Sri Lanka and received his medical degree from the University of Ceylon in that country. He trained for orthopaedic surgery in England where he was a fellow of the Royal College of Surgeons and the Royal College of Edinburgh. Dr. DeSilva came to Baltimore in 1976 for a fellowship study at the Maryland Shock Trauma Center. He practiced with Orthopedic Associates of Central Maryland. He was on the staff of the University of Maryland Medical Center, Howard County General Hospital, Harbor Hospital Center, and the James Lawrence Kernan Hospital. He was associate director of the Scoliosis Clinic at James Lawrence Kernan and was a former director of orthopaedic surgery at St. Agnes Hospital.

William E. Gilmore, M.D.

WILLIAM E. GILMORE, M.D., 83, died October 16 of congestive heart failure. A retired surgeon, Dr. Gilmore was a graduate of Princeton University and the Johns Hopkins School of Medicine. Dr. Gilmore taught surgery at the Johns Hopkins Hospital for more than 30 years.

He was also on the staff of Union Memorial Hospital and the Greater Baltimore Medical Center, and was chief of staff at Lutheran Hospital. For his many years of voluntary medical service at military facilities in Maryland, Dr. Gilmore was cited by Presidents Eisenhower, Kennedy, and Nixon. Dr. Gilmore was a member of the American Board of Surgery, the American Medical Association, the Southern Medical Association, and the Baltimore City Medical Society.

Edward W. Hopf, Sr., M.D.

EDWARD W. HOPF, SR., M.D., retired chief of the Bureau of Medical Services and Communicable Disease in the Baltimore County Health Department, died October 21 of heart disease at the age of 66. Dr. Hopf served during World War II in the navy as a hospital corpsman aboard a destroyer. After the war, he returned to Baltimore and graduated from Loyola College and the University of Maryland Medical School. He served an internship and residency at Mercy Hospital. Dr. Hopf had a general practice in East Baltimore before he returned to school full-time in 1964 to earn a master's degree from the Johns Hopkins University School of Hygiene and Public Health. Before retiring from the health department in 1988, Dr. Hopf was instrumental in establishing the Employees Health Clinic of Baltimore County. He was a member of the Baltimore County Medical Association.

No information was available at press time for the following members:

Dudley P. Jackson, M.D. (Affiliate) September 15, 1992
Frank R. Lewis, M.D. (Wicomico County) September 28, 1992
Irving Feinberg, M.D. (Montgomery County) October 18, 1992
Salvador Rossello, M.D. (Baltimore County) ■

*Please send information for In Memoriam to
 Wanda Griebel, Membership Services, Med Chi 1211
 Cathedral St., Baltimore, MD 21201-5585*

Auxiliary

Helping medicine through the legislative process

Often I get the impression that some physicians and auxiliaries do not understand how they can help the practice of medicine through legislation. Here are a few simple and effective actions requiring little time and effort. With some creative thinking, you can easily come up with even more ways to help.

1. Join MMPAC. Write a check for \$100. The Maryland Medical Political Action Committee (MMPAC) is made up of Med Chi members and auxiliaries. The MMPAC board includes members of the Med Chi Legislative Committee, as well as other politically active Med Chi members. The board determines how PAC money will be spent. Traditionally, it has been used throughout the state and divided equally between political parties.

2. Volunteer as the "Physician of the Day" for the Maryland General Assembly. It's a great way to get a behind-the-scenes look at how the legislative process works. Contact Joyce Yensen in Med Chi's Legal Department (410-539-0872 or 800-492-1056) or return the postcard in this journal with the dates you are available to volunteer. This year the dates are January 13 through April 12, Monday through Friday.

3. Write a response to a "Legislative Alert." Describe your personal experiences in order to convince legislators to vote for or against a particular bill. Legislators may not necessarily see the potential problems with a medical issue. Few of them have had any firsthand experience delivering health care. Your constructive comments will be highly regarded, particularly if you are a voter in their district.

4. Phone legislators to counsel them to vote on a issue. You could be an important link in the telephone bank, and your office staff could do the calling on your behalf. Many times Med Chi simply needs several calls to a delegate in your district saying, "vote for House Bill 000." There is no need to go into lengthy discussions about your position, just say, "vote for/against bill #000." A call can be completed in less than two minutes. There are 800 numbers for districts outside the Annapolis area. (See the Legislative Directory in this issue of the *MMJ*.)

5. Participate in a legislative hearing as an expert witness. Physicians are needed to add their expertise to the discussion of a bill. A lobbyist can try to explain some issues, but often only physicians know the answers to tough questions that are raised at hearings about the "real world" practice of medicine.

6. Attend a legislative hearing to show your support. Remember to sign the witness sheet even though you may not utter a word. This can be done by auxiliaries, too. I often think about the times I have seen hoards of people with personal stories crowding the hearing room for legislation on unorthodox medical practices. It makes an impression on the legislators.

7. Contact your friends. Urge them to write letters or call their legislators.

8. Help with the distribution of "Legislative Alerts." Even if you are not the originator of factual legislative information, you can help to see that this information is distributed to as many physicians and spouses as possible. Every county and hospital could improve in this area. Auxiliaries could be especially helpful.

9. Attend political fund-raisers paid for by MMPAC. Tell the politician that you are representing Med Chi. It will dispel the idea that doctors want to give only their money, but are not really interested in the candidates.

10. Talk to your neighbors, patients, friends, and family members. Tell them about the reality of the medical system and the bills pending in the legislature that represent problems or solutions.

11. Invite a legislator to your function. Get to know your legislators on a personal basis.

12. Attend legislative seminars. Keep informed about the bills before Congress and the Maryland General Assembly.

13. Become a member of Med Chi's Legislative Committee. Attend meetings in Baltimore to vote on Med Chi's position on each bill reviewed.

14. Attend the "Day in Annapolis." This year, the "Day in Annapolis" is on Thursday, January 21, 1993. (See accompanying story.)

15. Register to vote. Vote at every election.

16. Invite a legislator to join you on your rounds for a day or part of a day. This has been done successfully in other states. It is a project in the auxiliary's Legislative Project Bank. A legislator who accompanies a physician through one day's work may better understand a physician's daily problems and concerns. A greater rapport can also result from such an encounter.

With an increase in grassroots efforts, we can have an impact on a situation before it is too late. You will be glad you got involved.

SUE SHERWOOD



Auxilians: Attend the "Day in Annapolis"

Once again the Med Chi Auxiliary will host a "Day In Annapolis." The date this year is Thursday, January 21, 1993. Everyone is welcome. It is your chance to catch up on the issues and to talk one-on-one with your state legislators. Our morning discussions will include the most important issues being presented during the 1993 legislative session. As the auxiliary's state legislative chairperson, I think it is important to make everyone feel comfortable and be able to contribute to the legislative process. You can do so just by being there and expressing the concerns you and your spouse have about the health care delivery system. Our legislators are willing to listen to you.

The classic Harry Browne's Restaurant on State Circle will be the scene of our luncheon. As an Annapolis resident, I like to stick with a tried and true restaurant that is close to the State House so that any legislator can easily dash in and join us. The upstairs room offers a comfortable setting for casual conversations with our representatives. One year, our group from Anne Arundel County started a discussion about plans for a service project to which our

legislator gave several suggestions. You don't have to stick strictly to the issues; we are also trying to build a badly needed rapport between medicine and the legislature.

If you attend the "Day in Annapolis," you will be sure to have a good time and walk away with more confidence regarding dealing with the issues. And, by all means, **bring a friend.** Anyone who wishes to attend may make reservations by calling the Auxiliary Office at Med Chi (410-539-0872 or 800-492-1056).

SUE SHERWOOD ■

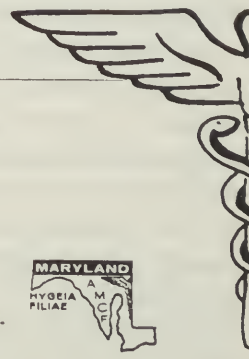
Sue Sherwood has been a member of Med Chi's Legislative Committee for six years and an MMPAC board member for four years, and has also served as the editor of *Maryland Medicine*, the MMPAC newsletter. She started a Legislative Committee six years ago in the Auxiliary to the Anne Arundel Medical Society. Keeping physicians informed about legislative issues is important to her.

MARYLAND

The Auxiliary always welcomes new members.

Auxiliary members support the physicians and are recognized for their contributions to health, education, and the promotion of quality health care in Maryland.

For information on becoming a member, call JoAnn Troisi at Med Chi's Auxiliary office.
539-0872 (Baltimore area) 1-800-492-1056 (toll free in MD)



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Medical Miscellany

"The Physicians' Campaign Against Family Violence"

"My husband had hit me so hard it broke my eardrum.... I didn't tell my physician what happened. I was too guilt ridden and embarrassed.... I thought the doctor would have wondered what I could have done to deserve it," said Charlotte Fedders, R.N., a former victim of family violence during

"By increasing our awareness and improving our skills, we can help reduce the problem of family violence," said MCMS President Carol Garvey, M.D., who moderated the discussion along with Robert I. Kurtz, M.D. of the Washington Psychiatric Society.

"We do more harm by omission," said Dr. Kurtz. He explained that many physicians may see the signs of domestic violence but rarely ask, "How did you get this bruise?" He adds that physicians should also be aware that nonverbal psychological abuse is more prevalent than physical abuse.

Ms. Toolan stated that many physicians hesitate to become involved in family violence cases because they do not want to testify in court. She added, however, that only a very few cases ever reach the judicial system. Research by the American Medical Association (AMA) shows that 80% of Americans feel they could talk with their physician if they had been the victim or the perpetrator of family violence.

Family violence is estimated to strike one in four American families. One in five emergency room visits by American women is attributable to family violence. Yet despite the high medical costs as a result of such visits, less than 5% of victims of family violence are ever identified.

"It's important that physicians know the cycle of family violence and recognize it," added Ms. Fedders, who is coauthor of *Shattered Dreams*. "I was very pleased to see the AMA begin its physician campaign against family violence," she said. Physicians are often the first to see the signs of family violence and have a vital role to play in recognizing, treating, and helping to prevent it.

Prior to the panel discussion, Med Chi President-elect Joseph Snyder, M.D. presented a certificate of recognition to the Montgomery County Medical Society for its efforts to increase awareness about this problem. Dr. Snyder also presented certificates to the Auxiliary to the Montgomery County Medical Society and to the Suburban Chapter of the Washington Psychiatric Society for hosting this joint meeting.



Family violence panelists (l to r): Charlotte Fedders, R.N.; Robert Kurtz, M.D.; Anne Frankel, M.D.; Carol Garvey, M.D.; and Kathleen Toolan, Esq.

the November Montgomery County Medical Society (MCMS) meeting. Ms. Fedders' unique perspective was part of "The Physicians' Campaign Against Family Violence," a panel discussion presented by MCMS designed to increase physician awareness of this widespread problem.

Other members of the panel included Anne Frankel, M.D., former director of the Child Abuse Clinic for the Montgomery County Health Department and Kathleen Toolan, Esq., assistant state's attorney. Dr. Frankel and Ms. Toolan also discussed the signs of child abuse. "There is no one group that this problem is limited to. It hits all racial, ethnic, socioeconomic, and religious classes," said Ms. Toolan. Victims can be men, women, children, adolescents, parents, or grandparents. Dr. Frankel added that family violence is "...difficult to deal with in a clinical setting" and that it is often several months before victims will acknowledge a problem.



Med Chi President-elect Joseph Snyder, M.D., presents a certificate of recognition to Montgomery County Medical Society President Carol Garvey, M.D.

Heart failure research prize

Qualified researchers studying any aspect of heart failure may submit original manuscripts for the \$30,000 Boots Heart Failure Research Prize sponsored by Boots Pharmaceuticals, Inc. Manuscripts should address basic or clinical research in heart failure, including the disciplines of biochemistry, biophysics, cellular biology, molecular biology, pathology, physiology, or pharmacology. The winning manuscript will be published in *Circulation Research*.

Applications must be received by the American Heart Association (AHA) National Center by May 1, 1993. Applicants must be residents of North America and hold a

position of full-time assistant professor, associate professor, or equivalent; be within five years of faculty appointment; work as an independent investigator; and not have previously presented the research at a national meeting or other young investigator competition.

The AHA Council on Circulation will award a \$1,000 honorarium to each of five finalists, plus another \$2,000 to the winner, as well as \$30,000 for the support of a fellow for one year—to be recognized as the Boots Fellow. The \$30,000 prize may also be applied by the investigator as an open grant toward laboratory expenses. For complete application instructions, contact AHA at 214-706-1595. ■

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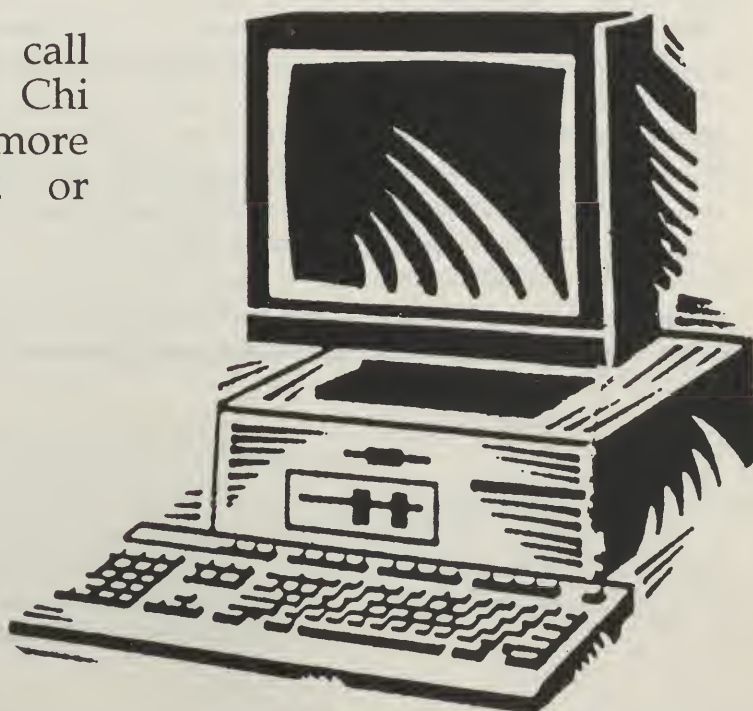
Grateful Med Training

Med Chi Physicians and Staff

On Wednesday, January 27, 1993 from 6-8 pm, the Med Chi Library will offer free training in Grateful Med at the University of Maryland Health Sciences Library. This training is open to Med Chi physicians and their staff.

Grateful Med software contains everything needed to obtain information from the National Library of Medicine (NLM) databases via a personal computer and modem. Although the Med Chi Library furnishes literature searches to member physicians at nominal fees as a privilege of membership, there are times when physicians prefer direct access to Medline and other National Library of Medicine databases for themselves and/or their staff. Since Grateful Med allows such access and is very easy to use, we are encouraging member physicians and/or their staff to attend this training.

Seating is limited; please call Steve Jones at the Med Chi Library to register or for more information (410-539-0872 or 1-800-492-1056).



University of Maryland

For each course, additional information may be obtained by contacting the Program of Continuing Education, University of Maryland School of Medicine, Room 14-011, BRB, 655 W. Baltimore St., Baltimore, MD 21201 (410-328-3956) or by calling the phone number listed after a specific program. FAX 410-328-3103.

- The Maurice C. Pincoffs lecture in medicine**, in Davidge Hall, UMAB campus. 1 Cat 1 AMA/PRA credit. Fee: none. Info: Theodore E. Woodward, M.D., 410-328-6070. Dec. 7
- HIV Counseling Skills I**, sponsored by the Maryland AIDS Professional Education Center, in Baltimore, MD. Info: Gwen Kergides, 410-328-8639. Dec. 8-11
- Advanced trauma life support**, sponsored by the Maryland Institute for Emergency Medical Services Systems, in Baltimore, MD. Info: Office of International Development, 410-328-2399. Mar. 10-11, 1993
- Managed care and quality improvement: Making a difference**, sponsored by the Maryland Institute for Emergency Medical Services Systems, in Baltimore, MD. Info: Office of International Development, 410-328-2399. Mar. 11, 1993
- Alcohol and trauma care**, sponsored by the Maryland Institute for Emergency Medical Services Systems, in Baltimore, MD. Info: Office of International Development, 410-328-2399. Mar. 11, 1993
- R. Adams Cowley 15th national trauma symposium**, sponsored by the Maryland Institute for Emergency Medical Services Systems, at the Hyatt Regency Baltimore, in Baltimore, MD. Info: Office of International Development, 410-328-2399. Mar. 12-14, 1993
- Infectious diseases in everyday medicine—3rd annual symposium**, at the Baltimore Convention Center, Baltimore, MD. 12.75 Cat 1 AMA/PRA credits. Fee: \$175 physicians before 4/1/93, \$200 after 4/1/93; \$100 allied health professionals before 4/1/93, \$125 after 4/1/93; \$50 fellows, residents and students before 4/1/93, \$75 after 4/1/93. Info: Eunice Katz, 410-706-7560. Apr. 19-20, 1993

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- Visiting professor program.** A directory of speakers and their topics is available to area hospitals and other health care organizations. NO administrative fees are charged for this service. Info: 410-328-3956.
- Visiting fellowship in interventional radiology.** Five-day practicum for radiologists, including conferences, patient rounds, and laboratory observations. By appointment only. 40 Cat 1 AMA/PRA credits. Fee: \$1,200.
- Ultrasound: Preceptorships.** For physicians or sonographers with six-month's experience in practicing ultrasound. By appointment only. 40 Cat 1 AMA/PRA credits. \$500.
- Departmental rounds and conferences.** Weekly, hands-on, and lecture presentations hosted by the university's clinical departments. Hour-for-hour Cat 1 AMA/PRA credits available. Brochure available.
- Pediatric grand rounds.** Every Thursday from September to June, except third Thursday, in the R. Adams Cowley Shock Trauma Auditorium. Info: Bonnie Winters, 410-328-6777.

Miscellaneous meetings

- | | |
|--|----------------------------|
| Williamsburg conference on heart disease , sponsored by the American College of Cardiology at the Williamsburg Conference Center, Williamsburg, VA. 18 Cat 1 AMA/PRA credits. Info: 800-257-4739. | Dec. 6-9 |
| Cardiovascular science and technology conference , sponsored by Association for the Advancement of Medical Instrumentation, Washington, DC. Info: 703-525-4890, ext. 210 or 212. | Dec. 12-14 |
| Maryland Academy of Family Physicians semiannual meeting , at Hyatt Regency Inner Harbor Hotel, Baltimore, MD. 10 Cat 1 AMA/PRA credits; 10 AAFP prescribed hours. Fee: \$100 MAFP members; \$150 nonmembers; \$60 paramedicals; No charge for residents, medical students, and MAFP life and retired members. Info: William P. Jones, M.D., 410-747-1980. | Jan. 30-31, 1993 |
| Cardiovascular conference at Snowshoe , sponsored by the American College of Cardiology, at the Mountain Lodge Conference Center, Snowshoe, W. VA. 13.5 Cat 1 AMA/PRA credits. Info: 1-800-257-4739. | Feb. 1-3, 1993 |
| Future relationships between community and university hospitals , sponsored by the Baltimore City Medical Society, at the Union Memorial Hospital, Baltimore, MD. 1 Cat 1 AMA/PRA credit. Fee: none. Info: 410-625-0022. | Feb. 4, 1993 |
| The cost of medicine in the future , sponsored by the Baltimore City Medical Society, at the University of Maryland Westminster Hall. 1 Cat 1 AMA/PRA credit. Fee: none. Info: 410-625-0022. | Mar. 4, 1993 |
| Clinical dilemmas in pulmonary practice , sponsored by the American Lung Association of Maryland and the Maryland Thoracic Society. 7 Cat 1 AMA/PRA credits. Info: Anne Eder, 410-560-2120 or 800-492-7527. | Mar. 7, 1993 |
| Headache in the decade of the brain symposium , presented by The Comprehensive Headache Center at the Germantown Hospital and Medical Center in Philadelphia, PA. 6 Cat AMA/PRA credits. Info: 215-951-8926. | Mar. 27, 1993 |
| Laboratory workshop in breast reconstruction , at the Sentara Norfolk General Hospital, Norfolk, VA. Info: 804-446-6140. | Mar. 25-27, 1993 |
| Hands-on workshop on advanced diagnostic methods in andrology , at the Jones Institute of Reproductive Medicine, Norfolk, VA. Info: 804-446-6140. | Apr. 8-9, 1993 |
| Thrombolysis: Its role in peripheral, arterial, and venous disorders , at the Omni International Hotel, Norfolk, VA. Info: 804-446-6140. | Apr. 23, 1993 |
| 195th annual meeting of the Medical and Chirurgical Faculty of Maryland , at the University of Maryland Center of Adult Education, College Park, MD. Info: Betsy Newman, 410-539-0872 or 1-800-492-1056. | Apr. 30-May 1, 1993 |
| Practical aspects of forensic medicine , sponsored by the Baltimore City Medical Society, at the Montebello Rehabilitation Hospital, Baltimore, MD. 1 Cat 1 AMA/PRA credit. Fee: none. Info: 410-625-0022. | May 6, 1993 |
| Practical dermatology for the primary care physician—19th edition , at the Ritz-Carlton Hotel, Pentagon City, VA. Info: 804-446-6140. | May 6-9, 1993 |
| Virginia Society of Otolaryngology-HNS annual meeting , at the Tides Inn Resort, Irvington, VA. Info: Donna Scott, 804-353-2721. | May 7-8, 1993 |
| Central Atlantic seminar in anesthesiology , sponsored by the George Washington University Medical Center, in Washington, DC. Info: John F. Vargo, 202-994-4285. | |
| Maryland Academy of Family Physicians 45th annual meeting and scientific session , at the Princess Royale Oceanfront Hotel and Conference Center, Ocean City, MD. 41.25 AMA/PRA Cat 1 credits; 41.25 AAFP prescribed hours. Fee: \$240 members; \$275 nonmembers; \$135 paramedicals; No charge for residents, medical students, MAFP retired and life members. Info: Francis C. Bruno, M.D., 410-747-1980. | May 18-23, 1993 |

- 6th annual trauma anesthesia and critical care symposium**, sponsored by the International Trauma Anesthesia and Critical Care Society (ITACCS) and Multinational Academic Consortium, at the Hyatt Regency, Baltimore, MD. Info: Kimberly C.A. Unitas, 410-328-2399. **May 20–22, 1993**
- Virginia Society of Ophthalmology annual meeting**, at the Norfolk Marriott Waterside, Norfolk, VA. Info: Donna Scott, 804-353-2721. **May 21–22, 1993**
- Ethics of death and dying in the young person**, sponsored by the Baltimore City Medical Society. 1 Cat 1 AMA/PRA credit. Fee: none. Info: Lorraine Wallace, 410-625-0022. **June 3, 1993**
- 9th annual Eastern Virginia Medical School family medicine review course**, at the Cavalier Hotel, Virginia Beach, VA. Info: 804-446-6140. **June 6–11, 1993**
- Board review in family practice**, sponsored by the George Washington University Medical Center, in Arlington, VA. Info: John F. Vargo, 202-994-4285. **June 12–16, 1993**
- 11th summer symposium in internal medicine**, at the Fort Magruder Inn & Conference Center, Williamsburg, VA. Info: 804-446-6140. **June 25–27, 1993**
- 16th annual flap dissection workshop**, at the Virginia Beach Conference Center. Info: 804-446-6140. **July 6–10, 1993**
- 14th international congress of lymphology**, sponsored by the International Society of Lymphology (ISL). Part 1: "Frontiers in Lymphology" at the Hyatt Regency, Baltimore, MD. Part 2: "Lymphology in 1993" at the Ramada Renaissance Techworld, Washington, DC. Info: Grace Wagner, program coordinator, 602-626-6118. **Sept. 20–26, 1993**
- Causes of the medical malpractice crisis**, sponsored by the Baltimore City Medical Society. 1 Cat 1 AMA/PRA credit. Fee: none. Info: 410-625-0022. **Oct. 7, 1993**

Continuously throughout the year

- Fluorescein angiography conference**, sponsored by the Retina Center, St. Joseph Hospital, Baltimore, MD, first and third Mondays of each month; 8:00-9:00 a.m. Fee: none. Info: R. Classon, 410-337-4500.

Statement of ownership, management, and circulation

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The Johns Hopkins Medical Institutions

All courses at the Thomas B. Turner Building unless otherwise indicated. For information on continuing medical education activities, contact the Office of Continuing Education, 720 Rutland Ave., Baltimore, MD 21205 (410-955-2959).

- Neural mechanisms of the auditory and vestibular systems II.** Cat 1 AMA/PRA credits available. Dec. 1–2
Fee: \$375 physicians; \$300 residents and fellows; \$450 allied health professionals.
- Clinical management of vestibular disorders.** Cat 1 AMA/PRA credits available. Fee: \$375 Dec. 3–4
physicians; \$300 residents and fellows; \$450 allied health professionals.
- Current concepts in lipidology and atherosclerosis,** at the Sheraton Inner Harbor Hotel, Balti- Dec. 4
more, MD. 8.5 Cat 1 AMA/PRA; 8 AAFP prescribed hours. Fee: \$100 physicians; \$75
residents, fellows, and allied health professionals.
- The Wilmer Ophthalmological Institute's current concepts in ophthalmology.** 20 Cat 1 Dec. 10–12
AMA/PRA credits. Fee: \$300 physicians; \$250 residents, fellows, and allied health profes-
sionals.
- Third annual conference on neurology for the primary practitioner,** at the Harbor Court Hotel, Dec. 12
Baltimore, MD. 6 Cat 1 AMA/PRA credits available. Fee: \$125 physicians; \$75 residents,
fellows, and allied health professionals.
- Endoscopic sinus surgery.** 19 Cat 1 AMA/PRA credits for lab and lectures; 14.5 Cat 1 AMA/PRA Jan. 7–8, 1993
credits for lecture only. Fee: \$1,250 for laboratory and lectures; \$295 for lecture series only.
- Advanced endoscopic sinus surgery.** 9 Cat 1 AMA/PRA credits. Fee: \$1,050. Jan. 9, 1993
- 1993 update in the management of age-related macular degeneration.** 6.5 Cat 1 AMA/PRA Jan. 22–23, 1993
credits for one-day course; 8.5 Cat 1 AMA/PRA credits for two-day course. Fee: \$200
physicians; \$100 residents, fellows, and allied health professionals; \$350 lectures and
optional lab course.
- Americans with disabilities act of 1992 and you.** Info: Dr. Jacqueline K. Corn, 410-955-2609 Jan. 29–30, 1993
- PET and SPECT brain imaging in clinical practice and research.** 18 Cat 1 AMA/PRA credits. Mar. 10–12, 1993
Fee: \$495 physicians; \$395 residents, fellows, and allied health professionals. Info: Patty
Campbell, 410-955-6046 or Julia Buchanan, 410-955-8582.
- Spectrum of developmental disabilities XV: PL 94-142; PL 99-457 - Issues of concern.** 20 Cat Mar. 15–17, 1993
1 AMA/PRA credits. Fee: \$425.
- Problems in the diagnosis and management of the dysphagic patient: Transatlantic perspec- Mar. 29–30, 1993
tives,** at the Stouffer Harborplace Hotel, Baltimore, MD. Cat 1 AMA/PRA credits available.
Fee: \$425 physicians; \$245 residents and allied health professionals.
- Diagnosis and treatment of neoplastic disorders, medical surgical, and radiotherapeutic Apr. 1–2, 1993
aspects.** 14.5 Cat 1 AMA/PRA credits. Fee: \$275; \$300 postmarked after February 1,
1993; \$125 physician-in-training.
- Current concepts in thyroid disease: Update 1993.** Cat 1 AMA/PRA credits available. Fee: \$150 Apr. 16, 1993
physicians; \$40 residents and fellows.
- 20th annual pediatric trends.** 45 Cat 1 AMA/PRA credits available. Fee: \$625 physicians; \$375 Apr. 19–24, 1993
residents and fellows.
- 34th annual postgraduate institute for pathologists in clinical cytopathology.** Course A: Home Apr. 19–30, 1993
study, March-April 1993. Course B: Lecture series with laboratory studies. 140 Cat 1
AMA/PRA credits.
- Principles and practice of clinical MRI,** at the Stouffer Harborplace Hotel, Baltimore, MD. Cat 1 Apr. 22–25, 1993
AMA/PRA credits available. Fee: TBA.
- XII international papillomavirus workshop,** at the Hyatt Regency Hotel, Baltimore, MD. 30 Cat 1 Apr. 22–25, 1993
AMA/PRA credits. Fee: \$400 prior to June 30, 1993; \$450 after June 30, 1993. Info:
Gretchen Shelton, 410-931-8108.

Pediatric allergy and immunology for the practitioner, 1 Cat AMA/PRA credit. Fee: TBA.

May 6-7, 1993

6th summer institute in environmental health studies. Info: Dr. Jacqueline Corn or Linda Lamb, 410-955-2609.

June 7-18, 1993

Continuously throughout the year

Visiting preceptorship in pediatric critical care medicine. Ongoing five-day preceptorship by appointment. 40 Cat 1 AMA/PRA credits. Fee: \$600.

The department of radiology and radiological sciences offers several courses in abdominal and obstetrical ultrasound. Info: P. Williams, 410-955-3169.

Visiting physicians. Offered throughout the year for experience in the lab and participation in read-in sessions; by appointment only. 40 Cat 1 AMA/PRA credits. Fee: \$500.

Johns Hopkins medical grand rounds. Accredited audiovisual continuing education series of case discussions for clinicians; thirty topics per year in five bimonthly programs. Individual and group subscriptions. 40 Cat 1 AMA/PRA credits. Info: 410-955-3988.



Consultation, a weekly radio program sponsored by the Medical and Chirurgical Faculty of Maryland allows Med Chi physicians to appear each week on WBAL to discuss the latest developments in medicine and to answer questions about health issues. Med Chi currently airs the following program of Consultation weekly:

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EPIDEMIOLOGY & DISEASE CONTROL PROGRAM

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December, 1992

Vaccine Information:

VIPs, Reportable Events following Immunization, Vaccine Handling and Storage, and Standards for Pediatric Immunization Practices

Vaccine Information Pamphlets (VIPs)

If any of the vaccines listed below are administered in your office or practice setting to children or to adults, the following information applies to you.

The National Childhood Vaccine Injury Act of 1986 (the Act), Public Health Service Act Section 2125 (42 USC 300 aa-26) **requires** that certain information about the benefits and risks of certain vaccines be provided to *each adult recipient or the parent/legal guardian* of a minor recipient *prior to administering any of these vaccines*. The following vaccines are included in this requirement:

1. Diphtheria, Tetanus, Pertussis (alone or in any combination): DTP, DT (pediatric), Td (adult), pertussis, or Tetanus toxoid vaccine
2. Polio (oral vaccine or injectable vaccine)
3. Measles, Mumps, Rubella vaccine(s) (alone or in any combination)

The Centers for Disease Control has developed Vaccine Information Pamphlets (VIP) for Diphtheria, Tetanus, and Pertussis (individual components or combinations); Measles, Mumps, and Rubella (individual components or combination); and Polio (oral or injectable vaccine). A new VIP supplementary statement on acellular pertussis vaccine has just been produced. These VIPs contain all information required by the Federal regulation. Although providers are required to provide specific written information, they

are not required to use the actual VIP. Providers may utilize other materials, as long as all required information is provided (see below).

In April, 1992, the Immunization Division, Department of Health and Mental Hygiene, (DHMH) mailed copies of the three VIP's to *all* licensed physicians in Maryland. We will soon mail the acellular pertussis VIP supplement statement. If you did not receive the mailing, or your copies were misplaced, you may receive one copy of each VIP by contacting the Immunization Division, DHMH, 201 W. Preston Street, Baltimore, Maryland 21201, (410) 225-6679. Providers may then reproduce or print additional copies as necessary. Also, providers may purchase the VIP's, in quantity, by calling the American Academy of Pediatrics at 1-800-433-9016.

Listed below is the specific information that must be provided to each adult recipient or parent/legal guardian of a minor recipient of the vaccines listed above. Additionally, for your reference, Table 1 contains a listing of *Reportable Events Following Immunizations*.

Information Required Prior to Immunization

Title XXI, Section 2126, of the Act, as amended by Public Law 100-203 and Public Law 100-239, requires that information in the vaccine information materials be presented in understandable terms, and specifically requires inclusion of the following:

TABLE 1. Reportable events following immunization*

Vaccine/Toxoid	Event	Interval from immunization
DTP, P, DTP/Poliovirus combined	A. Anaphylaxis or anaphylactic shock	24 hours
	B. Encephalopathy (or encephalitis) [†]	7 days
	C. Shock-collapse or hypotonic-hyporesponsive collapse [†]	7 days
	D. Residual seizure disorder [†]	†
	E. Any acute complication or sequela (including death) of above events	No limit
	F. (See package insert) [‡]	(See package insert)
Measles, Mumps, and Rubella; DT, Td, T toxoid	A. Anaphylaxis or anaphylactic shock	24 hours
	B. Encephalopathy (or encephalitis) [†]	15 days for measles, mumps, and rubella vaccines; 7 days for DT, Td, and T toxoids
	C. Residual seizure disorder [†]	†
	D. Any acute complication or sequela (including death) of above events	No limit
	E. (See package insert) [‡]	(See package insert)
Oral Poliovirus vaccine	A. Paralytic poliomyelitis — in a nonimmunodeficient recipient — in an immunodeficient recipient — in a vaccine-associated community case	30 days 6 months No limit
	B. Any acute complication or sequela (including death) of above events	No limit
	C. (See package insert) [‡]	(See package insert)
Inactivated Poliovirus vaccine	A. Anaphylaxis or anaphylactic shock	24 hours
	B. Any acute complication or sequela (including death) of above event	No limit
	C. (See package insert) [‡]	(See package insert)

*Events listed are required by law to be reported to the U.S. Department of Health and Human Services; however, VAERS will accept *all* reports of suspected adverse events after the administration of any vaccine.

†Aids to Interpretation:

- Shock-collapse or hypotonic-hyporesponsive collapse may be evidenced by signs or symptoms such as decrease in or loss of muscle tone, paralysis (partial or complete), hemiplegia, hemiparesis, loss of color or change of color to pale white or blue, unresponsiveness to environmental stimuli, depression of or loss of consciousness, prolonged sleeping with difficulty arousing, or cardiovascular or respiratory arrest.
- Residual seizure disorder may be considered to have occurred if no other seizure or convulsion unaccompanied by fever or accompanied by a fever of <102 F occurred before the first seizure or convulsion after the administration of the vaccine involved, AND, if in the case of measles-, mumps-, or rubella-containing vaccines, the first seizure or convulsion occurred within 15 days after vaccination OR in the case of any other vaccine, the first seizure or convulsion occurred within 3 days after vaccination, AND, if two or more seizures or convulsions unaccompanied by fever or accompanied by a fever of <102 F occurred within 1 year after vaccination.
- The terms seizure and convulsion include grand mal, petit mal, absence, myoclonic, tonic-clonic, and focal motor seizures and signs.
- Encephalopathy means any substantial acquired abnormality of, injury to, or impairment of brain function. Among the frequent manifestations of encephalopathy are focal and diffuse neurologic signs, increased intracranial pressure, or changes lasting ≥6 hours in level of consciousness, with or without convulsions. The neurologic signs and symptoms of encephalopathy may be temporary with complete recovery, or they may result in various degrees of permanent impairment. Signs and symptoms such as high-pitched and unusual screaming, persistent inconsolable crying, and bulging fontanel are compatible with an encephalopathy, but in and of themselves are not conclusive evidence of encephalopathy. Encephalopathy usually can be documented by slow wave activity on an electroencephalogram.

‡Refer to the CONTRAINDICATION section of the manufacturer's package insert for each vaccine.

the risk of any major adverse reactions to the vaccine that may occur.

4. Early warning signs or symptoms to which the recipient or parent/legal guardian should be alert as possible precursors to such major adverse reactions.

5. A description of the manner in which the recipient or parent/legal guardian should monitor such major adverse reactions, including a form on which reactions can be recorded to assist the legal representative in reporting information to appropriate authorities.

6. A specification of when, how, and to whom the legal representative should report any major adverse reaction.

7. The contraindications to (and basis for delay of) the administration of the vaccine.

8. An identification of the groups, categories, or characteristics of potential recipients of the vaccine who may be at significantly

higher risk of major adverse reaction to the vaccine than the general population.

9. A summary of:

- relevant Federal recommendations concerning a complete schedule of childhood immunizations; and
- the availability of the National Vaccine Injury Compensation Program; and
- such other relevant information as may be determined by the Secretary.

1. The frequency, severity, and potential long-term effects of the disease to be prevented by the vaccine.

2. The symptoms or reactions to the vaccine which, if they occur, should be brought to the immediate attention of the health care provider.

3. Precautionary measures the recipient or parent/legal guardian should take to reduce

Vaccine Handling and Storage

Proper storage and handling ensures optimal potency of vaccines, thereby maximizing efficacy of immunization. Are vaccine storage practices in your office correct?

A survey of 50 pediatric offices and clinics in the metropolitan Los Angeles area revealed some disconcerting findings (Pediatrics 1992; 89:193-196). Only 16% of vaccine storage coordinators knew appropriate storage temperatures for vaccine; 18% were unaware that heat can harm certain vaccines, and 36% did not know that freezing could also be harmful. Twenty-two percent of refrigerators had inappropriately high temperatures ($>8^{\circ}\text{C}$). Only 36% kept a thermometer in the refrigerator and only 20% regularly checked

the thermometer. Vaccines were stored on the door shelf rather than in the central core of the refrigerators in 46%. Outdated vaccine was found in 62%, and vaccine was stored outside the refrigerator for daytime use in 16% of offices.

The investigators concluded that vaccine storage errors occur in pediatric offices at an unacceptably high frequency. Guidelines for vaccine quality control in office practice are provided by the authors. The box below contains recommendations for proper vaccine handling and storage. Additional recommendations can be found in Pediatrics 1991; 87:108-112.

Recommendations for Proper Vaccine Handling and Storage

1. Store *all vaccines except OPV* at $35 - 46^{\circ}\text{F}$ or $2-8^{\circ}\text{C}$ (refrigerate but *do not freeze*). Also, see specific manufacturer inserts.
2. Store MMR at $35 - 46^{\circ}\text{F}$ or $2-8^{\circ}\text{C}$ in the refrigerator. Do not allow vaccine to warm up or to be exposed to light before use. Discard within 8 hours of reconstitution.
3. Store OPV in the freezer at 14°F or -10°C . Thaw before using; OPV may be rubbed between hands for rapid thawing. Do *not* allow to stand and warm up to room temperature. The number of freeze-thaw cycles must be documented as well as the total thaw time. Do not exceed 10 freeze-thaw cycles.
4. Do not store any refrigerated vaccines next to refrigerator coils or in the freezer compartment where they may freeze. Stack vaccine neatly with an air space between stacks to allow cool air to circulate.
5. Store a small container of water in the freezer. If the water consistently remains frozen, then the freezer is functioning properly for OPV storage.
6. Do not store vaccine on the door shelf of the refrigerator or freezer.
7. Make one person responsible for monitoring vaccine. Have a person designated as back-up.
8. Check the core refrigerator/freezer temperatures and record in a vaccine log at least once each business day.
9. "First In, First Out"--use the vaccine with the shortest expiration date first and discard or return out-of-date vaccine. Check monthly for presence of outdated vaccine.
10. Do a hand count inventory at least once a month. This allows you to anticipate vaccine needs and to monitor vaccine usage.
11. Do not store food or drinks in the same refrigerator with your vaccine.

Standards for Pediatric Immunization Practices

The recent measles epidemic in the United States led the National Vaccine Advisory Committee (NVAC) to look at pediatric immunization practices. The NVAC's recommended Standards for Pediatric Immunization Practices were developed by a working group with representatives from private and public sector organizations and from numerous state and local health departments. They were approved by the United States Public Health

Service and endorsed by the American Academy of Pediatrics. Even though not all providers are expected now to be in compliance, the Standards are expected to be useful as a means of helping providers identify needed changes, obtain resources, and implement desirable immunization practices in the future. How many Standards does your practice currently meet (see below)?

Standards for Pediatric Immunization Practices

1. Immunization services are *readily available*.
2. There are *no barriers* or *unnecessary prerequisites* to the receipt of vaccines.
3. Immunization services are available *free* or for a minimal fee. (Note: In Maryland, the new Child Wellness legislation will require insurers to cover immunizations that are recommended by the Immunization Practices Advisory Committee--thereby making vaccines more affordable for many parents.)
4. Providers utilize all clinical encounters to *screen* and, when indicated, immunize children.
5. Providers *educate* parents and guardians about immunization in general terms.
6. Providers *question* parents or guardians about *contraindications* and, before immunizing a child, *inform* them in specific terms about the risks and benefits of the immunizations their child is to receive.
7. Providers follow only true *contraindications*.
8. Providers administer *simultaneously* all vaccine doses for which a child is eligible at the time of each visit.
9. Providers use accurate and complete *recording procedures*.
10. Providers *co-schedule* immunization appointments in conjunction with appointments for other child health services.
11. Providers *report adverse events* following immunization promptly, accurately, and completely (see Table 1).
12. Providers operate a *tracking system*.
13. Providers adhere to appropriate procedures for *vaccine management*.
14. Providers conduct semi-annual *audits* to assess immunization coverage levels and to review immunization records in the patient populations they serve.
15. Providers maintain up-to-date, easily retrievable *medical protocols* at all locations where vaccines are administered.
16. Providers operate with *patient-oriented* and *community-based* approaches.
17. Vaccines are administered by *properly trained* individuals.
18. Providers receive *ongoing education* and *training* on current immunization recommendations.

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AMA Key Policies Include In PRO Program

Success! Throughout 1992, the AMA's Board of Trustees, Council on Medical Service, and AMA staff have combined to play a critical role reshaping the PRO program to embrace key AMA policy. In the Fourth Scope of work, starting April 1, 1993, HCFA will:

- replace the existing Quality Intervention Plan "point system" with a more "educational" Quality Review Process;
- require physician reviewers to be licensed in the state where the services are performed and to routinely care for Medicare beneficiaries;
- compel PROs to actively use practicing consultants in relevant specialties when drafting new review criteria or changing existing criteria, and to consider comments from state medical associations in formulating criteria;
- for the *first* time, require PROs to allow physicians to ask for reconsideration of final notice of a quality concern determination;
- charge PROs to assess the potential impact on physician reviewers if their names are released to the physicians being reviewed; and
- minimize case-by-case review in favor of pattern analysis.

AMA "Waived" Advocacy Lightens Lab Burdens

The CLIA Advisory Committee unanimously recommended that the minimally regulated "physician performed" category of clinical laboratory tests be established. This category of testing was vigorously advocated by both the AMA and twenty

two specialty societies. The CDC is expected to accept the recommendation, also supported by HHS Secretary Louis Sullivan, MD. The AMA will meet with the CDC to discuss types of tests to be included in the "physician performed" category.

Health Care Reform: AMA Positioned as Major Player in 1993

Health system reform will be one of the top three priorities for the 103rd Congress and the new Administration. Fortunately, the AMA is firmly positioned as a major player, thanks to the Health Access America campaign that was up and running long before presidential electioneering began.

The AMA decided that doctors did not want to wait for someone else to come along and tell us what to do. The AMA issued its own platform in March 1990 when we brought out the far-reaching plan for health care reform, Health Access America. It was one of the first comprehensive proposals for private and public change, and drew immediate nationwide attention. The plan's basic elements -- universal coverage, employer mandate, competition and freedom of choice for patients -- speak directly to core issues of access, cost control and quality care.

Some saw Health Access America as a challenge; others saw it as a model. In most proposals receiving serious attention, you will find elements of Health Access America. The bottom line is that everyone agrees that the crisis in health care access and cost has become so severe that change is needed. The public, our patients, agree that health care reform is right up there with the economy and jobs as the most urgent issues facing the nation.

As far as doctors are concerned, we are working to ensure that organized medicine has a seat at the negotiating

table, to make a strong case for needed change.

You may have seen our ads in *Time*, *Newsweek*, *The New York Times*, *The Washington Post*, *US News & World Report*, *Fortune* and *Business Week* which spells out that Health Access America builds on the existing strengths of the medical and health care system. In the private sector, employers would be required to provide insurance for employees and their dependents. Government would provide coverage for the unemployed and indigent, making coverage universal. Our patients would be free to choose their own doctor, hospital and insurance plan.

We don't need a nationalized health system. We need a national health system solution: Health Access America.

The AMA, with the strong and steady support of the federation, has been a powerful advocate for change throughout this long, vigorous national debate. With your help, this kind of advocacy can become stronger. The 1992 election was the first step; every doctor has a stake in what comes next.

Be active in organized medicine. Claim your own seat at the health care reform table. It's the only way your voice will be heard ... and your voice may well make the difference in the long-term health of us all.

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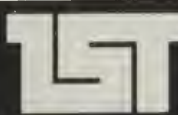
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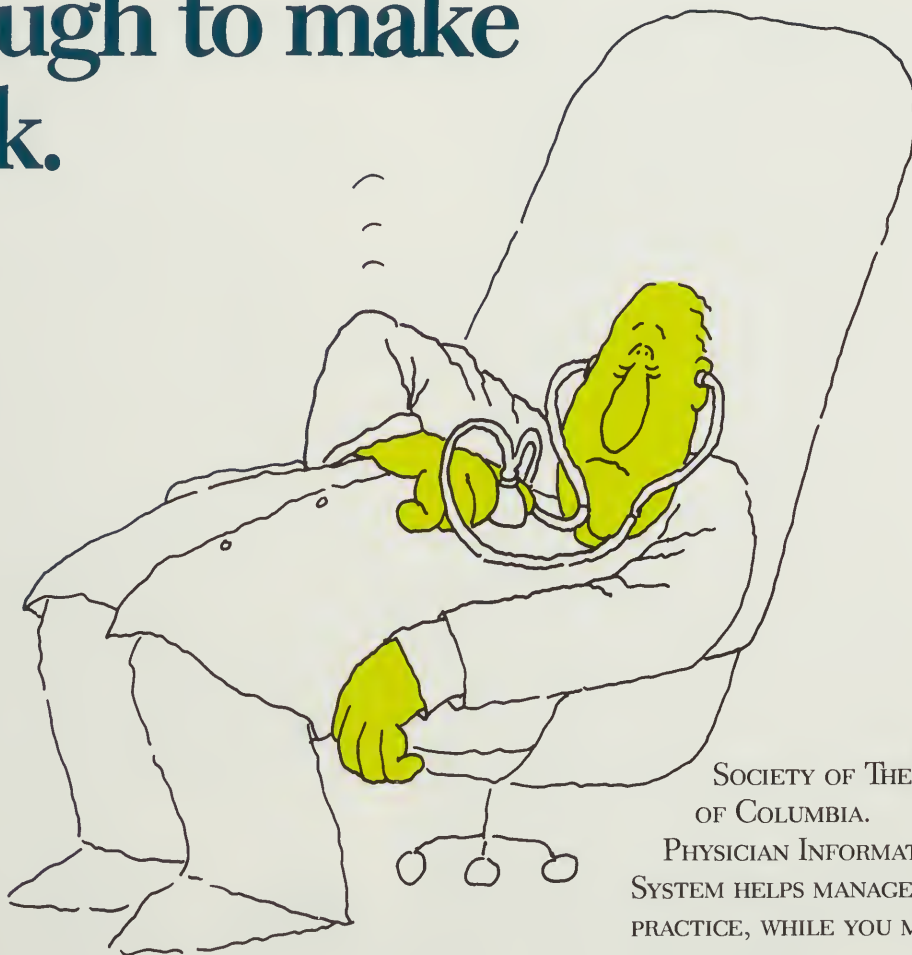
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